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State/Territory Name: Wyoming

State Plan Amendment (SPA) #: 23-0007

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
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

July 21, 2023

Mr. Lee Grossman
State Medicaid Agent
Division of Healthcare Financing
Herschler Building
122 West 25th Street, 4 West
Cheyenne, WY 82002

Re: Wyoming State Plan Amendment (SPA) 23-0007

Dear Mr. Grossman:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 23-0007. This amendment proposes to update the requirements for Third Party Liability – Payment of Claims for Third Party Liability- Identifying Liable Resources.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations of the Bipartisan Budget Act of 2018, Section 53102. This letter is to inform you that Wyoming Medicaid SPA 23-0007 was approved on July 21, 2023, with an effective date of April 1, 2023.

If you have any questions, please contact Ford Blunt at 214-767-6381or via email at Ford.Blunt@cms.hhs.gov.

Sincerely,

Digitally signed by James G. Scott -S
Date: 2023.07.21 11:37:29 -05'00'

James G. Scott, Director
Division of Program Operations

cc: Lee Grossman
Sheila McInerney

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23-0007

2. STATE: WY

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

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

4. PROPOSED EFFECTIVE DATE: 04/01/2023

5. TYPE OF PLAN MATERIAL (Check One) ☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION
Updating Attachments 4.22-A and 4.22B as a result of the Bipartisan Budget Act of 2018. Section 53102, Third Party Liability and updating the State Plan

7. FEDERAL BUDGET IMPACT
a. FFY 2023 $ 0
b. FFY 2024 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.22-A, Pages 1-3
Attachment 4.22-B, Pages 1-3
Page 69a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)
Attachment 4.22-A, Pages 1-3 (TN 17-0007)
Attachment 4.22-B, Pages 1-3 (TN 00-008)
Page 69a, Page (TN 00-005)

10. SUBJECT OF AMENDMENT

Updates to the Requirements for Third Party Liability – Payment of Claims and for Third Party Liability - Identifying Liable Resources

11. GOVERNOR'S REVIEW (Check One)

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED – Delegated to Lee Grossman, State Medicaid Agent, Division of Healthcare Financing

12. SIGNATUR STATE AGENCY OFFICIAL

13. TYPED NAME: LEE GROSSMAN

14. TITLE: STATE MEDICAID AGENT

15. DATE SUBMITTED: April 26, 2023

16. RETURN TO:
LEE GROSSMAN
STATE MEDICAID AGENT
OFFICE OF HEALTH CARE FINANCING
122 WEST 25TH STREET, 4 WEST
CHEYENNE, WY 82002

CC: SHEILA MCINERNEY, TPL & ESTATE RECOVERY SPECIALIST
(SAME ADDRESS)

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: April 26, 2023

18. DATE APPROVED: July 21, 2023

PLAN APPROVED - ONE COPY ATTACHED

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

20. SIG ONAL OFFICIAL
Digitally signed by James G. Scott -S
Date: 2023.07.21 11:37:59 -05'00'

21. TYPED NAME: James G. Scott

22. TITLE: Director, Division of Program Operations

1. Frequency of data exchanges (42 CFR 433.138(f)):

   A. SSA Wage, State Wage Information Collection Agencies (SWICA), and Title IV-A: Not utilizing these data sources currently. The Agency has an alternate source of information that furnishes information as timely, complete and useful as these files in determining the legal liability of third parties pursuant to 42 CFR 433.138(d)(2).
   B. Commercial health insurance carriers: Monthly
   C. Workers compensation: Monthly
   D. Motor Vehicle: Monthly
   E. Diagnosis and Trauma Codes: Monthly

2. Timeliness of follow-up (42 CFR 433.138(g)(1)(i) and (g)(2(i)):

   A. SWICA & SSA Wage – 433.138(g)(1)(ii) and IV-A data exchange – 433.168(g)(1(ii)

   The Agency is not utilizing these data sources currently. The Agency has an alternate source of information that furnishes information as timely, complete and useful as these files in determining the legal liability of third parties pursuant to 42 CFR 433.138(d)(2). However, the Agency will begin to perform data matching with SWICA by July 01, 2023. All new clients over the age of 14 will be sent to the Wyoming Department of Workforce Services (DWS) to verify state wage data. If a change in income is disclosed prior to the annual renewal of eligibility, a record will be sent to DWS to confirm income information. For any new and ongoing clients, eligibility records are sent from the Agency to its claims vendor who creates a commercial insurance lead for verification of health insurance coverage by the TPL vendor.

   During the application for and upon annual renewal of Wyoming Medicaid benefits, applicants and clients are asked to provide third party coverage information. This data is transmitted daily from the eligibility system to the claims processing system creating a "TPL Leads" file (Leads File). The Leads File is included in the eligibility extract from the claims processing vendor and transmitted to the TPL vendor. The TPL vendor conducts data matching for all clients included in the eligibility file with private health insurance companies described below. Any confirmed TPL coverage is transmitted from the TPL vendor to the claims processing vendor on a daily basis and loaded into the client's TPL File. Since the process is conducted daily, it occurs more frequently than the quarterly SWICA and SSA Wage data match. When new health insurance information is verified, it is transmitted daily from the TPL vendor to the claims processing vendor for cost avoidance of claims. This data matching process is not just targeting individuals with income that may have private health insurance, it is

targeting any applicant or client with disclosed private health insurance and any newly eligible clients.

B. Commercial Health Insurance Carriers – 433.138(g)(2)

Health insurers in Wyoming are required by state statute to disclose private health care eligibility for all individuals eligible for and provided medical assistance by the agency, and for the individuals' spouses or dependents. The TPL vendor receives eligibility data for 96% of the Wyoming lives covered by health insurance carriers.

At the time of application for and renewal of Medicaid benefits, applicants are requested to disclose health insurance coverage information. Eligibility workers have 45 days to incorporate eligibility data into the eligibility database and determine financial eligibility. On a daily basis, an eligibility file is transmitted from the eligibility vendor through SFTP and by the system integrator to the claims processing vendor with suspected health insurance coverage information. The claims vendor uses this information to create a Leads File. This leads data is included in an eligibility extract and transmitted daily to the TPL vendor. Through an algorithm and data matching logic, the TPL vendor matches Medicaid eligibility data to eligibility information from private health insurance companies. Any confirmed health insurance coverage is transmitted daily from the TPL vendor to the claims vendor who updates the TPL eligibility file in the claims processing system. Cost avoidance is immediate through electronic edits in the claims processing system.

On a weekly cadence, a paid claims file is transmitted to the TPL vendor, who screens and determines which claims are the responsibility of another health insurance company. Post payment recovery is initiated within 60 days of receipt of the extract. The TPL vendor maintains the TPL recovery records on its database.

C. Workers Compensation – 433.138(g)(2)

No cost avoidance occurs with workers compensation data. On a monthly basis through the system integrator and by Secure File Transfer Protocol (SFTP), a vendor receives two files from Wyoming's Department of Workforce Services, Workers' Compensation Division. The workers claim record file contains active workers compensation payments issued since the last reporting period. The vendor uses this file to perform data matching against the paid claims file to identify overlapping payments made by the Agency and the Department of Workforce Services. The second file is the workers compensation case file. It contains new workers compensation cases in the state of Wyoming since the last reporting period. The vendor uses demographic data from this file to perform a match against the Agency's

eligibility file. Within 60 days, the vendor begins the post-payment recovery process and tracks all actions in the TPL tracking database.

D. Follow through on motor vehicle data match – 42 CFR 433.138(g)(3)):

The agency executed a Memorandum of Understanding (MOU) with the Department of Transportation, Highway Safety program. Pursuant to this MOU, the agency, or their designee, is authorized to access the state of Wyoming motor vehicle crash data. The TPL vendor runs a predefined ad hoc report on a monthly basis displaying all individuals injured in motor vehicle accidents. The TPL vendor performs a data match between Medicaid's eligibility file and the report of the injured parties utilizing the injured party's first name, last name, date of birth, and date of loss. For any confirmed matches, the TPL vendor pulls claims data, determines if Medicaid has paid accident related claims totaling $250.00 or more, pulls accident reports to determine who the responsible parties are. Within 45 days, the vendor will verify discrepant information and notify liable third parties of Medicaid's reimbursement right, requests reimbursement, and tracks all actions in the TPL tracking database.

E. Trauma diagnosis codes (433.138(g)(4))):

The Agency contracts with a vendor to identify and pursue paid claims that are indicative of trauma, injury, poisoning or other external causes for the purposes of ascertaining the legal liability of third parties. Through the use of algorithms, the vendor determines whether the client should be sent a trauma code mailer based upon cost effectiveness criteria. The vendor begins the post-payment recovery process within five days of determining a claim meets the trauma code criteria. The vendor maintains the TPL case data on their database.

The Agency's TPL program is designed to function primarily as a cost avoidance system. This method was chosen as the most efficient and cost effective option. Claims for medical services, unless excluded by federal law, are cost avoided when a third party liability exists within Agency's claims payment system. In certain circumstances, a vendor pursues post payment recovery of claims when confirmed third party coverage is loaded into the member's TPL file after the claims are paid as described in this attachment.

1. Monitoring provider compliance (42 CFR 433.139(b)(ii)(C):

   The State Plan as referenced herein requires providers to bill third parties. When the probable liability of a third party is established, the Agency notifies the provider that the claim was cost avoided due to the existence of TPL. Cost avoided services/claims are identified with Claim Adjustment Reason and Remark Codes, Remittance Advice Remark Codes, and claim error codes transmitted to the provider with non-payment on the provider's remittance advice. Providers are able to access third party coverage information through an online secure web portal. The Agency further certifies that our claims processing system enforces cost avoidance for prenatal services, including labor, delivery, and postpartum care services. The only exceptions to the cost avoidance requirements are as follows:

   A. Under the exemption authority found in 42 CFR 433.139(b) and 42 CFR 433.147(c), children that have been placed in the Wyoming Department of Family Services' custody (DFS) or related entities are excluded from TPL cooperation.

      (i) The Agency will use standard "pay and chase" when processing claims unless it is confirmed that the child's life will be put in jeopardy (e.g. medical support order).

   B. Under the exemption authority found in 42 CFR 433.139(b)(3)(i), the Agency makes payments without regard to potential third party liability for preventative pediatric services, including early and periodic screening, diagnosis and treatment services (EPSDT), unless the state has made a determination related to cost effectiveness and access to care that warrants cost-avoidance for up to 90 days.

      (i) Wyoming will use standard "pay and chase" when processing claims for preventative pediatric services.

   C. Under the exemption authority found in 42 C.F.R. 433.139(b)(3)(ii), the state has flexibility to make payments without regard to potential TPL for up to 100 days for claims related to child support enforcement beneficiaries, In regard to child support services, the Agency chooses to make payment within 30 days as it is cost-effective and necessary for access to care.

(i) Wyoming will use standard "pay and chase" when processing claims for child support enforcement beneficiaries.

Providers are monitored for compliance with insurance billing requirements through a post payment recovery process by a vendor. The vendor is responsible for identifying claims with potential third party liability where Medicaid has paid primary. The vendor will either directly bill the primary insurance or will perform disallowance by requesting the provider seek payment from the primary insurance and Wyoming's payment will be recouped.

If a provider has billed a third party and has not received payment, the provider will be required to submit a form as proof that they attempted to bill the third party two times within a 90-day period and have not received payment. The provider must have waited 90 days from the date of service and not received payment from the third party before the Agency will pay.

2. Guidelines Used to Determine When to Seek Reimbursement from a Liable Third Party (42 CFR 433.139(f)(2)):

A. Health Insurance

For medical claims that were paid by Wyoming prior to the TPL policy being entered into the claims system, recovery is pursued by a vendor from the provider for amounts greater than $10.00 within eleven months from the date of service. The timeframe is only one year from the date of the service if the provider would need to bill Medicare.

For medical claims that were paid by Wyoming prior to the TPL policy being entered into the member's eligibility file in the claims processing system, recovery is pursued by a vendor from the liable third party payer for amounts greater than $0.01 within a timeframe of twelve months to three years of the claim from date of service.

B. Casualty Threshold

The Agency does not have a threshold amount for casualty insurance claims; however, priority is given to identifying third party liability for those members who have had at least $250.00 in trauma related claims during the month. Those individuals with less than $250.00 in claims are worked as time permits.

C. Casualty Recovery

For casualty recoveries, the agency complies with 42 U.S.C. Section 1396(a)(25)(B) and uses the following factors and guidelines in determining whether to pursue recovery of benefit, after deduction of the agency's proportionate share of attorney's fees and costs, from a liable party.

(i) Ascertain the amount of the Medicaid reimbursement right and the amount of the gross settlement.

(ii) Determine whether the Medicaid right to reimbursement plus attorney's fees and costs will exhaust or exceed the settlement funds.

(iii) If the answer to 2 (ii) is Yes; and if the agency:

(a) Is informed the client will not pursue the claim; or

(b) Cannot handle the case, once it is tendered to the agency by the client or the client's attorney to pursue on behalf of the client; or

(c) Made reasonable effort to ascertain the client's intention regarding the claim, but could not obtain a response; then the agency shall follow procedures stated in (iv).

(iv) The agency shall consider the cost-effectiveness principle in determining the estimated net recovery amount to be pursued, based on the likelihood of collections. Net recovery amount is defined as that amount of recovered dollars to apply to Medicaid costs. In determining the estimated recovery amount, the following factors will be considered:

(a) Settlement as may be affected by insurance coverage or other factors relating to the liable party;

(b) Factual and legal issues of liability as may exist between the client and liable party;

(c) Problems of proof faced in obtaining the award or settlement; and

(d) The estimated attorney's fees and costs required for the agency to pursue the claim.

After considering the above factors, the agency may pursue a lesser recovery amount to the extent that the agency determines it to be cost-effective to do so.

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: ___________________WYOMING_________________________________

Citation

Citation			
42 CFR 433.139 (b)(3)(ii)(A)	__X__	(c)	Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.
		(d)	ATTACHMENT 4.22-B specifies the following:
42 CFR 433.139(b)(3)(ii)(C)			(1) The method used in determining a provider's compliance with the third §433.139(b)(3)(ii)(C).
42 CFR 433.139(f)(2)			(2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery or reimbursement would not be cost effective.
42 CFR 433.139(f)(3)			(3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.
42 CFR 447.20		(e)	The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.