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State/Territory Name: WY

State Plan Amendment (SPA): 23-0015

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604

Financial Management Group

January 17, 2025

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

RE: TN 23-0015

Dear State Medicaid Agent Lee Grossman:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Wyoming state plan amendment (SPA) to Attachment 4.19-B WY 23-0015, which was submitted to CMS on September 29, 2023. This plan continues outpatient hospital supplemental payments and authorizes a new supplemental payment for physicians.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2023. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact LaJoshica Smith at 214-767-6453 or via email at lajoshica.smith@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: WY-23-0015

2. STATE: Wyoming

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

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

4. PROPOSED EFFECTIVE DATE: 07/01/2023

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION
42 CFR, Section 447.272

7. FEDERAL BUDGET IMPACT
a. FFY 2024 $ 0 - budget neutral
b. FFY 2025 $ 0 - budget neutral

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Amendment 4.19-B:
1. 4.19-B, Part 1, Page 27 (QRA)
2. 4.19-B, Part 1, Page 28-30 (Hosp OP UPL Calc)
3. 4.19-B, Part 1, Page 31-32 (PHS Pay OP)
4. 4.19-B, Part 1, Page 33-40 (WY20-006 (PSSP)

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

Amendment 4.19-B:
1. 4.19-B, Addendum 1, Page 24A, WY03-003 (QRA)
2. 4.19-B, NEW Pages (Hosp OP UPL Calc)
3. 4.19-B, Addendum 2, Page 24B, WY16-008 (PHS Pay OP)
4. 4.19-B, Addendum 4, Page 27 - 30, WY20-006 (PSSP)

10. SUBJECT OF AMENDMENT

Updates to the calculation of hospital outpatient supplemental payments for the Qualified Rate Adjustment (QRA) program and the Private Hospital Supplemental (PHS) payment program.

Documentation of the current calculation methodology for the hospital outpatient UPL and the Professional Services Supplemental Payment (PSSP) Upper Payment Limit.

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED

Delegated to Lee Grossman, State Medicaid Agent, Division of Healthcare Financing

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME: Lee Grossman

14. TITLE: State Medicaid Agent

15. DATE SUBMITTED: 09/29/2023

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 29, 2023

18. DATE APPROVED: January 17, 2025

PLAN APPROVED - ONE COPY ATTACHED

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

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME: Todd McMillion

22. TITLE: Director, Division of Reimbursement Review

23. REMARKS

Instructions on Back

Outpatient Hospital Services

Qualified Rate Adjustment (QRA) Payments

A hospital located in Wyoming may be eligible for an outpatient Qualified Rate Adjustment (QRA) payment if:

1. It is owned or operated by a non-state governmental entity; and

2. Its calculated hospital outpatient Medicaid Upper Payment Limit (UPL)for the payment period is greater than its total projected pre-QRA outpatient Medicaid claim Allowed Amount for the same period.

The QRA payment is an annual lump sum supplemental payment equal to a portion of the difference between a qualifying hospital's calculated Medicaid Upper Payment Limit (UPL) for the payment period and its pre-QRA Medicaid Allowed Amount for the same period. This difference is referred to as the "UPL gap." If a hospital's UPL gap is negative (that is, total Medicaid outpatient claim Allowed Amount is greater than the hospital's Upper Payment Limit), then their QRA payment will be zero.

The sum of the Medicaid claim Allowed Amounts and the QRA payments will not exceed Medicaid Upper Payment Limits for any UPL category as defined in 42 CFR, Section 447.272. If one or more hospitals within a UPL category have claim Allowed Amounts greater than their Upper Payment Limits, then QRA payments are reduced proportionately so that total Medicaid payment for the hospitals in that UPL category does not exceed the UPL for that category. QRA payments will not be subject to cost settlement.

Please see Attachment 4.19-B, Part 1 for a description of the calculation of hospital outpatient Upper Payment Limits.

OUTPATIENT HOSPITAL UPPER PAYMENT LIMIT CALCULATION

I. Overview of Wyoming Medicaid's Upper Payment Limit Methodology

The following describes the methodology for creating Wyoming Medicaid's annual hospital outpatient Upper Payment Limit (UPL) demonstration to comply with the Centers for Medicare and Medicaid Services' (CMS') UPL demonstration requirements. UPL demonstrations require a comparison of rate-year (a.k.a. "demonstration year") Medicaid payment to an estimate of rate-year Medicare payment for Medicaid reimbursable services provided to Medicaid recipients. The estimate of rate-year Medicare payment is referred to as the Upper Payment Limit or "UPL amount." The Wyoming Department of Health performs a prospective UPL demonstration, using claim data from a base year that aligns with each hospital's most currently available cost report and applies rate-year Medicaid and estimated Medicare pricing to these claims. The UPL test is performed by comparing rate-year Medicaid and estimated Medicare payments by provider class – State-Owned, Non-State Government Owned, and Private. If the Medicaid payments for those services are equal to or less than the reasonable estimate of what would have been paid using Medicare payment principles, the State meets the UPL test.

For hospital outpatient services, the State estimates what would have been paid using Medicare payment principles by calculating 101 percent of reasonable cost for Critical Access Hospitals (CAHs) and 100 percent of reasonable costs for non-CAHs. The State uses this approach to estimate Medicare payment for all Medicaid services covered under the hospital outpatient UPL calculation, including those not covered by the Medicare program. Estimate of Medicare payment for the rate year includes inflating hospital cost from the timeframe in which services were performed to the timeframe of the rate year. The State also adds the Medicaid portion of hospital Provider Assessment costs to inflated claim costs to get the UPL amount.

If Wyoming Medicaid rates have not changed between the base year and the rate year, then the Allowed Amount on the base year claims is used as the Medicaid payment amount for purposes of the UPL demonstration. If the Wyoming Medicaid outpatient rates have changed between base year and the rate year, then the outpatient claims are repriced using the rate year pricing parameters. In addition, the State includes hospital outpatient Qualified Rate Adjustment (QRA) supplemental and Private Hospital Supplemental (PHS) payments in the total Medicaid payments for the rate year.

II. Overview of Assignment of Provider Class

Each hospital is assigned to a UPL provider class defined by CMS. These are state owned or operated, non-state government owned or operated and privately owned or operated. Wyoming Medicaid uses forms providers submit to request consideration for QRA payment to determine provider ownership. In

the UPL demonstration spreadsheets, we group providers to UPL categories based on ownership type.

III. Estimating Hospital Cost on Medicaid Claims

(a) Collect cost report data: Extract total hospital ancillary operating costs, capital costs, and ancillary service charges from the Medicare cost reports, as follows:

i. Worksheet B Part I – operating costs and capital costs for reimbursable services. Exclude costs not directly associated with hospital outpatient services such as costs from a skilled nursing facility.

ii. From Worksheet C Part I – Respiratory Therapy/Physical Therapy (RT/PT) adjustments, non-physician anesthetist costs, ancillary charges, and costs for the same cost center lines as selected from Worksheet B Part I.

(b) Calculate cost-to-charge ratios for ancillary services. Ancillary services are those services reported in cost center lines 50 – 104, with some exclusions within that range such as services and drugs provided in the home. Ancillary cost report lines are mapped to ancillary hospital cost centers, and a cost-to-charge ratio is calculated for each unique hospital cost center.

i. Identify ancillary services using cost center lines 50 – 104 from the Medicare cost report (Worksheets B and C). Exclude those cost centers that do not represent inpatient hospital services, such as the cost center "Federally Qualified Health Center."

ii. Map the cost report lines to ancillary hospital cost centers.

iii. Develop cost-to-charge ratios for hospital outpatient services for each ancillary cost center using the following formula for all services:

$$\text{Cost-to-Charge Ratio} = \frac{\text{Subtotal costs (Worksheet B, Part I, Column 24)} \text{ less non-physician anesthetist costs (Worksheet B, Part I, Col 19)} \text{ plus RT/PT (Worksheet C, Part I, Column 2)}}{\text{Charges (Worksheet C, Part I, Column 8)}}$$

iv. Determine a provider summary cost-to-charge ratio. The provider summary ancillary cost-to-charge ratio equals the ratio of aggregate ancillary costs to aggregate ancillary charges.

v. Intern and resident medical education costs, if reported by the provider, are not included in the outpatient ancillary cost-to-charge ratios.

(c) Estimate reasonable costs for outpatient hospital claim service lines.

i. Identify charges using field "Submitted Charges" on Wyoming Medicaid claim service line data and exclude non-covered charges.

ii. Assign a hospital cost center to each claim line based on revenue code.

iii. Estimate costs by multiplying service line charges by the corresponding provider and cost center-specific cost-to-charge ratio. If a provider's cost-to-charge ratio for an individual cost center is 0, then apply the cost-to-charge ratio from a similar cost center, if one is available, otherwise apply the provider's aggregate ancillary cost-to-charge ratio.

iv. Inflate costs from the midpoint of the hospital's cost report period to the midpoint of UPL demonstration year.

(d) Estimate the costs of the Private Hospital Provider Tax for outpatient services. CMS allows the cost of the Medicaid portion of a provider tax to be included in the UPL calculation when using a cost-based methodology. The Private Hospital Provider Tax in Wyoming is assessed at an aggregate level for all outpatient services based on net patient revenues from the Medicare cost report. Because the patient revenues represent those from the entire hospital, we distribute the resulting assessment specifically to Medicaid as well as distribute it between inpatient and outpatient services.

i. Retrieve hospital net patient revenue from Worksheet G-3 of each hospital's cost report.

ii. Calculate assessment rate by dividing the non-federal share of total supplemental payments to hospitals by total patient revenue.

iii. Calculate the annual hospital outpatient assessment by hospital by multiplying the hospital's total patient revenue by the assessment rate.

iv. Determine an outpatient assessment payment percentage for each hospital as the hospital's Medicaid submitted charges associated with outpatient services divided by the hospital's total Medicaid submitted charges.

v. Multiply each hospital's annual assessment amount by the outpatient assessment payment percentage to determine the outpatient portion of the assessment amount.

vi. Multiply the resulting annual outpatient assessment amount by the provider's Medicaid Inpatient Utilization Rate (MIUR) to get the provider tax costs applicable to the Medicaid outpatient services. Because there is no outpatient equivalent of the MIUR, we use the inpatient utilization rate to identify the Medicaid portion of the annual assessment for outpatient services.

PRIVATE HOSPITAL SUPPLEMENTAL (PHS) PAYMENT – OUTPATIENT

I. Subject to the provisions of this section, a privately owned and operated hospital located in Wyoming shall be eligible for a private hospital supplemental payment each quarter (based on a yearly calculation) to compensate such hospitals for the costs of covered hospital outpatient services furnished to Wyoming Medicaid patients.

II. The amount available within the Private Hospital Supplemental Payment pool will equal the aggregate Upper Payment Limit (UPL) gap for privately owned and operated hospitals. The UPL gap is calculated to be the total of the difference between the Allowed Amount that would have been calculated under Medicare payment principles in accordance with 42 CFR 447.272 (Upper Payment Limit) and the Medicaid Allowed Amount calculated for such services by the Medicaid agency.

III. A privately owned and operated hospital may be eligible for a PHS payment if its calculated UPL gap prior to applying supplemental payments is positive (that is, if the UPL is greater than estimated Medicaid Allowed Amount for the payment period). If a hospital's UPL gap is negative, the hospital's PHS payment will be zero.

Private hospital outpatient supplemental payment will be equal to a percentage of each hospital's UPL gap based on each hospital's UPL gap as a proportion of the aggregate UPL gap for all private hospitals. If one or more hospitals within the Private Hospital UPL category have claim Allowed Amounts greater than their Upper Payment Limits, then PHS payments are reduced proportionately so that total Medicaid payment for the hospitals in the Private Hospital UPL category does not exceed the UPL for this category. Please see the table below for an example.

	Outpatient UPL Available for Payment			**Outpatient Supplemental Payments**	
Hospital	**Medicaid Deficit**	**Medicaid Payments Exceeding UPL**	**Amount Available for UPL Payments**	**Outpatient Payment Distribution Percentage**	**Total Outpatient Supplemental Payment**
	A	B	C = B – A	D = C / A	E
Hospital A	100,000	–	100,000	[redacted]	85,000
Hospital B	200,000	–	200,000		170,000
Hospital C	300,000	–	300,000		255,000
Hospital D	400,000	–	400,000		340,000
Hospital E	–	150,000	(150,000)		–
Total	**1,000,000**	**150,000**	**850,000**	**85.00%**	**850,000**

Aggregate payments to private hospitals, including claim payments and all private hospital supplemental payments shall not exceed the Medicaid UPL as defined in 42 CFR 447.272.

IV. Private hospital supplemental payments will be distributed in equal quarterly lump sum payments.

Please see Attachment 4.19-B, Part 1 for a description of the calculation of hospital outpatient Upper Payment Limits and UPL gap.

1905(a)(5)(A) Physician Services

Professional Services Supplemental Payments and Upper Payment Limit Calculation

Subject to the provisions of this section, effective July 1, 2020 individual providers and provider groups owned or operated by licensed hospitals meeting the definition of "health care provider" (pursuant to 42 CFR 433.52) and located in Wyoming shall be eligible to participate in the Professional Services Supplemental Payment (PSSP) program which allows for supplemental payments to qualified clinicians based on an annual calculation. The PSSP excludes inpatient and outpatient services.

1. Eligible Clinicians

The following services shall be eligible to be included in the PSSP program:

a) Services provided by Physicians including Physician Assistants and Nurse Practitioners;

b) Services provided by Certified Registered Nurse Anesthetists;

c) Services provided by Certified Nurse Midwives;

d) Services provided by a Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Counselor, and Licensed Addiction Therapist;

e) Home Health Care Services not otherwise provided as inpatient or outpatient services;

f) Chiropractic Services;

g) Optometric/optician Services;

h) Therapist services, defined to include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological services, and rehabilitative specialist services not otherwise provided as inpatient or outpatient services;

i) Psychological Services;

j) X-ray Services defined as services provided in a licensed, free-standing x-ray facility. This definition does not include x-ray services provided in a hospital inpatient department or hospital outpatient department

In order to qualify to receive supplemental payments, the physician or professional service practitioner must be:

a) Licensed by the State of Wyoming

b) Enrolled as a Wyoming Medicaid provider

c) A provider type that provides the covered services listed above

d) Employed by, or under contract to provide services at or in affiliation with an in-state hospital and identified by the hospital as a physician or practitioner that is employed by, under contract to provide services at, or in affiliation with the hospital.

To have provider groups included in the PSSP program, hospitals must confirm clinician ownership or affiliation and provide required commercial payer fee schedules or paid claims information for the provider groups.

2. Individual Provider Upper Payment Limit Calculation Based on Claim Payments

The Upper Payment Limit (UPL) for each provider is based on the amount Wyoming commercial payers would reimburse service providers using Centers for the Medicare and Medicaid Services' (CMS) Medicare Equivalent of the Average Commercial Rate (ACR) methodology.

Following this method, the Department periodically, as required by the CMS, collects commercial rates by procedure code, modifier, and place of service combination for at least three commercial payers from each provider group owned or operated by an in-state hospital. Commercial payers exclude Medicare, Medicare Advantage/HMO, TRICARE, Medicaid, and worker's compensation payers. Once the data is collected, the Department calculates an ACR for each unique combination of hospital, procedure code, modifier, and place of service. The Department limits its data collection and analysis to services covered within the Medicaid program.

The Department will extract paid claims with first date of service in the preceding calendar year for provider groups that qualify for inclusion in the PSSP program. The claim data set includes services provided to Medicaid fee-for-service recipients. The Department will align the provider group's ACR for each procedure code, modifier, and place of service combination to each Medicaid claim for services furnished by the provider group and calculate the average commercial payments for the claims. The average commercial rates assigned to claim lines are multiplied by paid units, as applicable for each procedure code, to estimate commercial payment for each provider and service combination.

The Department requests rates from the top three commercial payers from each provider. If a provider has less than three commercial rates, the Department will include all the commercial rates available. If no rates are available from a provider for a particular procedure code, modifier, and place of service combination, then a statewide average commercial rate will be applied for that service.

The Department then estimates Medicare Allowed Amount on each professional claim service line. The Medicare rates used are the most currently available national rates that align with the UPL rate year.

Next, the Department separately totals for each provider the average commercial payment and estimated Medicare payment and calculates a Commercial-to-Medicare Ratio (CMR). The provider specific CMR is multiplied by estimated Medicare Allowed Amount on each claim service line to determine the commercial payment amount for each Medicaid claim service line. The commercial payment amounts are then summed on all claims from all providers affiliated with a hospital to determine the UPL amount for each provider. This amount is also referred to as the Medicaid payment ceiling.

The Average Commercial Rates and Commercial-to-Medicare Ratios will be re-determined every three years. The Department may add new physicians or physician groups to the PSSP payment calculations annually as long as they are affiliated with a hospital for which commercial rates have been collected, or are affiliated with a new hospital for which commercial rates are collected.

3. Supplemental Payment Calculation

The PSSP amount available for each provider group owned or operated by an in-state hospital participating in the PSSP program will equal the difference between the Medicaid payment ceiling and the amount paid for the same services by the Wyoming Department of Health (the Department). The Medicaid payment ceiling will be calculated using the Medicare Equivalent of the Average Commercial Rate method as described above. In cases where the provider's projected annual

Medicaid claim Allowed Amount is greater than the Medicaid payment ceiling from all applicable clinicians, then the provider does not qualify for a supplemental payment for the year.

If Medicaid rates for professional services did not change between the base year (timeframe of the claim data) and the rate year, then Medicaid Allowed Amount is simply retrieved from the claim data. If Medicaid rates have changed between the two time periods, then the claims are repriced to reflect Medicaid reimbursement levels for the UPL rate year.

The amount of the supplemental payment for each provider will be equal to the difference between the calculated annual Medicaid payment ceiling and the Medicaid claim Allowed Amount.

PSSP supplemental payments are made prospectively and are not subject to cost settlement. Non-state government owned (NSGO) providers will receive one payment per state fiscal year. Privately owned providers will receive one-fourth of their annual allotment once every quarter of the state fiscal year.

4. Upper Payment Limit Demonstration

An Upper payment limit demonstration will be completed annually using claim data from a recent 12-month period, allowing time for billing and claims adjudication runout and applying supplemental payments calculated through the process described in this section of the state plan.

The Medicare Equivalent of the Average Commercial Rates ratios effective July 1, 2024 and applicable to all the clinicians affiliated with each hospital participating in this program are shown in the table below:

Hospital	Medicare Equivalent of the Average Commercial Rate Ratio
Campbell County Memorial Hospital	2.404
Cheyenne Regional Medical Center	1.866
Community Hospital	2.136
Crook County Hospital	1.590
Evanston Regional Hospital	3.011
Hot Springs County Memorial Hospital	4.572
Ivinson Memorial Hospital	1.834
Johnson County Healthcare County	2.475
Memorial Hospital of Carbon County	2.849
Memorial Hospital of Converse County	1.749
Memorial Hospital of Sweetwater County	3.010
Niobrara Community Hospital	2.513
North Big Horn Hospital	4.299
Platte County Memorial Hospital	2.155
Powell Hospital	3.653
SageWest Healthcare - Riverton	2.249
Sheridan Memorial Hospital	3.162
South Big Horn County Hospital	4.896
South Lincoln Medical Center	2.512
St. John's Medical Center	2.178
Star Valley Medical Center	2.560
Summit Medical Center	2.647
Washakie Medical Center	1.859
West Park Hospital	3.196
Weston County Health Services	6.134
Wyoming Behavioral Institute	2.440
Wyoming Medical Center	1.834