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State/Territory Name: Wyoming

State Plan Amendment (SPA) #: 25-0004

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

September 12, 2025

Lee Grossman
State Medicaid Agent
Division of Healthcare Financing
122 West 25th, St. 4 West
Cheyenne, WY 82002

TN-25-0004

Dear Agent Grossman,

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Wyoming state plan amendment (SPA) to Attachment 4.19-A WY 25-0004, which was submitted to CMS on June 26, 2025. This plan amendment provides updates to inpatient hospital reimbursement including the removal of provider categories receiving DRG base rates, and specific categories for which policy adjustors are applied for.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 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, 2025. 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 Sudev Varma at 301-448-3916 or via email at sudev.varma@cms.hhs.gov

Sincerely

[redacted]

Rory Howe
Director
Financial Management Group

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: 25-0004

2. STATE: WY

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
7/1/2025

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447 Subpart C

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 0
b. FFY 2026 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
4.19-A, Part 1, Pg. 3, Pg's. 5 - 15

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
4.19-A, Part 1, Pg. 3, Pg's. 5 - 15 (Supersedes TN# WY-23-0014)

9. SUBJECT OF AMENDMENT
Updates to inpatient hospital reimbursement including the removal of provider categories receiving Diagnosis Related Group (DRG) base rates and the specific categories for which policy adjusters are applied.

10. 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:

[redacted]FFICIAL

12. TYPED NAME
Lee Grossman

13. TITLE
State Medicaid Agent

14. DATE SUBMITTED
06/26/2025

15. RETURN TO
Lee Grossman
State Medicaid Agent
Division of Healthcare Financing
122 West 25th, St. 4 West
Cheyenne, WY 82002

CC:

FOR CMS USE ONLY

16. DATE RECEIVED
June 26, 2025

17. DATE APPROVED
September 12, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director of Financial Management Group

22. REMARKS

Instructions on Back

(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 Wyoming Medicaid Rule Chapter 3, Section 8, which is incorporated by this reference.

Section 7. Wyoming Medicaid Participating Providers. Participating providers are all in-state Wyoming providers and out-of-state providers that are currently enrolled in the Wyoming Medicaid program and received at least eight-hundred thousand ($800,000) in Wyoming Medicaid payments for inpatient services during the most recently available 36-month period based on each claims last date of service. Wyoming Medicaid requires a minimum of six months for billing and claim processing before defining a month as "available" for this determination..

Section 8. Medicaid Allowable Payment for Inpatient Acute Care Hospital Services

(a) Most inpatient acute care hospital services will be reimbursed using Wyoming Medicaid's All-Patient Refined Diagnosis Related Groups (APR DRG) reimbursement methodology.

(b) The Wyoming APR DRG reimbursement methodology shall apply to all inpatient stays for Wyoming Medicaid recipients at Wyoming Medicaid enrolled participating and non-participating hospitals except as specified in Subsection (m). This change shall be effective February 1, 2019.

(c) Wyoming's DRG payment method will use APR DRG codes and national relative weights. APR DRG codes and relative weights are updated annually, and the Department shall update the version of the APR DRG codes and relative weights it applies to claims no more than once per year, unless an error is identified in the payment parameters, and at least once every three years.

(d) The DRG Allowed Amount will be calculated as DRG Base Payment plus an outlier payment as applicable, plus the prospective flat capital payment rate for dates of service prior to October 1, 2023. On and after October 1, 2023, funds previously reserved for DRG capital add-on payments will be incorporated into the DRG base rate and separate capital payments will not be reimbursed. Adjustments for patient transfers and less than one day stays are also made.

(e) The version of APR DRG code, associated hospital base rate, and associated payment parameters assigned to a claim are determined based on the last date of service on the claim.

(f) Components of the APR DRG payment are described in the following sections:

(G) Claims qualifying for the Transfer Payment Policy are eligible for outlier payments.

(iv) Less-Than-One-Day Stay Payment Policy

(A) An inpatient claim qualifies for the Less-Than-One-Day Stay Payment Policy if the patient was in the hospital for less than 24 hours and the claim is not for one of the following:

- Birth
- Vaginal delivery
- Patients who pass away on their first day in the hospital
- Patients who are transferred to another acute care hospital
- Services assigned a transfer APR DRG
- Other services defined by the Department for which an inpatient stay less than 24 hour may be deemed appropriate. All services that may fall within the "other services" category are defined in the DRG calculator published at: https://www.wyomingmedicaid.com/portal/Diagnosis-Related-Grouping.

(B) Final DRG Base Payment on claims that qualify for the Less-Than-One-Day Stay Payment Policy will equal a DRG Per Diem amount which will be calculated as [(DRG Base Payment) / (DRG national average Length of Stay)].

(C) Claims that qualify for the Less-Than-One-Day Stay Payment Policy will not be eligible for a DRG outlier payment.

(h) Calculation of hospital DRG base rate

(i) A base rate represents a dollar amount used in the calculation of Medicaid Allowed Amount.

(ii) The base period for development of the Wyoming APR DRG rates contains a minimum of 24 months and a maximum of 36 months of available claims data based on claim last date of service. Wyoming Medicaid requires a minimum of six months for billing and claim processing before defining a month as “available” for this determination.

(iii) Base rates for APR DRG services are assigned for categories of hospitals as needed to meet the Department’s payment policy goals. Each certified hospital that provides inpatient acute care hospital services to Wyoming Medicaid recipients is assigned to a base rate category by the Department.

(iv) The Department establishes base rates so that projected APR DRG payments maintain budget neutrality for each base rate category for claim payments between the base period and the new rate period unless otherwise directed by the Wyoming Legislature.

(v) Only one base rate is available to each provider at a given period of time.

(vi) The Department posts base rates for each provider category on the Department website. New rates will be posted with a provider notice sent by the Department when any changes are made to the APR DRG base rates. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of (ex. case management for persons with chronic mental illness). The agency's fee schedule rate was set as of July 1, 2025 and is effective for services provided on or after that date. All rates are published at: https://www.wyomingmedicaid.com/portal/Diagnosis-Related-Grouping.

(vii) Base rates and associated payment parameters are updated each time the Department implements a new version of APR DRGs. A set of base rates apply only for a specific version of APR DRGs.

(i) APR DRG relative weights

(i) The Department assigns each claim a relative weight using the APR DRG version in effect on the claim's last date of service. Wyoming will update the APR DRG version and corresponding relative weights at most once per year and at least once every three years.

(ii) Each APR DRG is assigned a relative weight that is listed in the DRG calculator under Section 8 *Medicaid Allowable Payment for Inpatient Acute Care Hospital Services* and can be found at: https://www.wyomingmedicaid.com/portal/Diagnosis-Related-Grouping.

(iii) The Department uses national APR DRG relative weights calculated by the organization that develops and maintains the APR DRG categorization system.

(iv) During the rate modeling for the provider base rates used in the initial year of the APR DRG implementation, the Department applied a documentation and coding improvement (DCI) factor of five percent to the relative weights to account for coding improvements made by providers following the implementation of APR DRGs. Following the first year of implementation, the Department will review coding improvement and may make future DCI adjustments to account for observed changes in provider coding in order to maintain budget neutrality, in aggregate, for inpatient hospital services.

(j) APR DRG policy adjustors

(i) One policy or age adjustor can be applied per claim.

(ii) Policy adjustors are multipliers that may increase or decrease payment are applied in the calculation of DRG Base Payment.

(iii) Policy adjustors are assigned for various categories of services defined by the Department as needed to promote access to inpatient care for WY Medicaid recipients.

(iv) The Department assigns APR DRG codes to the service categories used for policy adjustors based on APR DRG code description and service lines assigned by the organization that develops and maintains APR DRGs.

(k) Outlier Payments

(i) The Department will make outlier payments for high cost claims in which an estimate of hospital financial loss for the stay exceeds a predetermined fixed loss threshold.

(A) The fixed loss threshold is listed in the DRG calculator under Section 8 *Medicaid Allowable Payment for Inpatient Acute Care Hospital Services* and is published at: https://www.wyomingmedicaid.com/portal/Diagnosis-Related-Grouping.

(B) If a provider's cost for a claim minus the DRG base payment exceeds the hospital's assigned fixed loss threshold the provider will receive an outlier payment.

(ii) The outlier payment is calculated as follows:

(A) Identify the cost of each claim by multiplying allowable charges on the claim by a hospital-specific cost-to-charge ratio.

(B) Participating providers are assigned the most recently available provider-specific cost-to-charge ratios developed annually by the Department.

(C) For dates of service prior to October 1, 2023, non-participating hospitals are assigned the average cost-to-charge ratio from in-state participating hospitals for the outlier calculation. For dates of discharge on or after October 1, 2023, non-participating hospitals are assigned the average cost-to-charge ratio from out-of-state participating hospitals for the outlier calculation.

(D) Calculate estimated hospital loss as estimated hospital allowable cost minus DRG Base Payment.

(E) If the estimated hospital loss exceeds the provider's fixed-loss outlier threshold, an outlier payment will be added to the DRG base payment.

(F) The outlier payment shall be a percentage of the estimated hospital loss.

(l) Capital Payments

(i) For dates of discharge prior to October 1, 2023, Wyoming will provide a per discharge capital payment to participating providers.

(ii) For claim with last date of service between February 1, 2019 and December 31, 2020, capital payments are set at $277.87 per discharge, as determined during the 2010 level of care rebasing, and will not be inflated.

(iii) For dates of service between January 1, 2021 and September 30, 2023, capital payments are set at $270.92 per discharge.

(iv) A description of capital payment calculations is located in Section 13.

(v) Effective October 1, 2023, a separate capital payment will not be applied for claims priced via the APR DRG method. Instead, the funds previously paid via Capital Payments have been incorporated into the determination of DRG base rates and standard DRG payments.

(vi) Final reimbursement amounts will be equal to a claim's allowed amount minus any deductions for recipient cost sharing, patient responsibility, third-party liability or hospital acquired conditions (HACs).

(vii) The Department will use the APR DRG grouper to review for hospital acquired conditions based on present on admission (POA) indicators required for hospitals' submission on all claims to be priced using the APR DRG method. 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. If the presence of a HAC would increase payments, the Department will not provide additional reimbursement for the treatment of the acquired conditions.

(m) Exempted Services and Providers

(i) Wyoming's APR DRG system as implemented on February 1,2019, will not apply to rehabilitation claims, which will continue to be reimbursed using a per diem payment as described in Section 9 of this document.

(ii) Eligible transplant services will be reimbursed at a level that covers the provider's eligible costs for the transplant services as calculated using billed charges and the most recently available provider-specific cost-to-charge ratios developed annually by the Department as part of the Department's Medicaid hospital supplemental payment policy calculations.

(n) Interim Claims. Acute care hospitals reimbursed through the APR DRG method will not be allowed to submit interim claims.

(o) Prior Authorization. The Department will still require prior authorization for rehabilitation, psychiatric, transplant, and other services determined by the Department and communicated services through provider manuals or other updates.

Section 9. Payment for Rehabilitation Claims

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

(b) Payment shall be comprised of a per diem rehabilitation operating cost payment and a per diem capital cost payment, as determined for purposes of the 2010 rehabilitation level of care rebasing.

(i) A description of the capital payment calculation is located in Section 13.

(ii) The Department determined the per diem rehabilitation operating cost payment as the hospital-specific average cost per diem as calculated for purposes of the 2010 rehabilitation level of care rebasing.

(c) The Department calculated the allowable cost of each rehabilitation claim for each participating hospital (as identified for purposes of the 2010 rehabilitation level of care rebasing) using hospitals' as-filed Medicare cost reports for hospital fiscal years ending in state fiscal years 2005 and 2006 and hospitals' inpatient claims paid in state fiscal years 2006 and 2007 (base period). Medical education costs were not considered allowable.

(d) The Department identified base period allowable costs as the sum of routine per diem costs and ancillary service costs.

(iii) Base period allowable costs were inflated forward from the date of service to the midpoint of SFY 2007 using the CMS-PPS Hospital Market Basket.

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

(v) The Department calculated a cost per day for each hospital for rehabilitation services.

A. For each hospital, the Department divided total costs for rehabilitation services in the base period by total days from the base period claims data.

B. High and low-cost Medicaid outlier costs were identified for rehabilitation costs per diem.

C. The Department determined the base period allowable Medicaid cost per diem for rehabilitation services for each hospital by subtracting high and low-cost Medicaid outliers from the costs determined in paragraph (A).

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

(vii) The Department calculated the ventilator payment per day 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.

(e) Reimbursement of non-participating hospitals

i. The Medicaid payment rate for the rehabilitation services will be the average payment rate for all participating providers.

ii. The Medicaid payment rate for non-participating hospitals shall not include reimbursement for capital costs.

(f) The Department will accept interim claims for inpatient rehabilitation services.

Section 10. Reimbursement of New Hospitals.

(a) The Medicaid APR DRG base rate for new hospitals shall be the APR DRG base rate assigned to other hospitals with similar characteristics.

(b) The Medicaid rehabilitation payment rate for new hospitals shall be the average rehabilitation per diem payment for all participating providers.

(c) The Medicaid payment rates for new hospitals shall remain in effect until the APR DRG system or the rehabilitation per diem payment is rebased.

Section 11. Reimbursement of Merged Hospitals. The Medicaid allowable APR DRG and rehabilitation payment for a merged hospital shall be:

(a) The APR DRG and rehabilitation payment rates of the surviving hospital;

(b) A capital payment (if applicable):

i. For rehabilitation services, the capital payment shall be the statewide capital payment per diem amount as described in section 13.

ii. For services reimbursed via the APR DRG method and with last date of service prior to October 1, 2023, the capital payment shall be the statewide per-discharge amount as described in section 13.

Section 12. 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 21 of this Attachment.

Section 13. Reimbursement of Capital Costs.

(a) Capital payment for eligible APR DRG services with last date of service prior to October 1, 2023:

i. The Department will use the per discharge capital payment rate determined for non-rehabilitation levels of care during the 2010 level of care rebasing.

ii. The Department calculated the allowable capital cost for each participating hospital using hospitals' as-filed Medicare cost reports for hospital fiscal years ending in state fiscal years 2005 and 2006 and hospitals' inpatient claims paid in state fiscal years 2006 and 2007.

iii. The Department calculated a capital cost per discharge for each participating hospital included in the 2010 level for care rebasing by dividing total capital costs by total discharges based on the data identified in (i).

iv. The Department arrayed the average capital cost per discharge of all participating hospitals and selected the median capital cost per discharge for the capital payment rate for all participating hospitals.

v. Effective January 1, 2021, the Department reduced this payment by 2.5% based on legislative direction.

(b) For eligible APR DRG services with last date of service on or after October 1, 2023, funds previously used for capital payments have been incorporated into DRG payments and no separate capital payment will be assigned.

(c) Capital payment for eligible rehabilitation services –

i. The Department will use the per discharge capital payment rate determined for the rehabilitation level of care during the 2010 level of care rebasing.

ii. The Department identified the per diem capital payment by dividing the median capital cost per discharge as calculated in subparagraph (a) by the average length of stay of all participating hospitals included in the 2010 level of care rebasing with rehabilitation services discharges.

iii. The capital payment amount for rehabilitation services shall not exceed the per discharge amount calculated in subparagraph (a),

(d) An adjustment to a provider's capital rate pursuant to subsection (e) will not result in the redetermination of the statewide average prospective capital rate.

(e) No capital payment shall be made to non-participating providers.

(f) Adjustments to capital rates. A provider may request an adjustment of its capital rate pursuant to Section 22 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.

(g) Capital rates shall not be inflated.

Section 14. Reimbursement of Swingbed Services. Reimbursement for swingbed services shall be pursuant to Wyoming Medicaid Rule Chapter 28.

Section 15. Third-Party Liability.

(a) Submission of claims. Claims for which third-party liability exists shall be submitted in accordance with Wyoming Medicaid Rule 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 16. 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 17. 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) Disallowances. If a field audit or desk review discloses non-allowable costs or overpayments, the Department shall recover any overpayments pursuant to Section 21 of this Attachment.

(e) 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 22. The reconsideration shall be limited to whether the Department has complied with the provisions of this Attachment.

(f) 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 21.

(g) 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 18. Rebasing. The Department shall rebase rates when the rates determined pursuant to this Attachment no longer meet the requirements of the Social Security Act. The Department has the discretion to update rates based on changes to hospital peer groups, hospital billing practices or changes in hospital operations, or updates in DRG codes.

Section 19. Payment of Claims.

(a) Payment of claims shall be pursuant to Wyoming Medicaid Rule Chapter 3, 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 20. Partial Eligibility

(a) The Department maintains a partial eligibility policy in which providers submit claims only for days the recipient is an eligible Medicaid recipient.

(b) The claim admit date is the actual admit date, and the number of days billed includes only the dates for which the recipient is eligible even if s/he stayed longer.

Section 21. Recovery of Overpayments. The Department shall recover overpayments pursuant to Wyoming Medicaid Rule Chapter 16, which is incorporated by this reference. The Federal

share of payments made in excess will be returned to CMS in accordance with 42 CFR Part 433, Subpart F.

Section 22. Reconsideration. A provider may request reconsideration of the decision to recover overpayments pursuant to the provisions of Wyoming Medicaid Rule Chapter 16.

Section 23. 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 24. 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 25. 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 26. Severability. If any portion of this Attachment is found to be invalid or unenforceable, the remainder shall continue in effect.