Certification Page
Regular and Emergency Rules
Revised September 2016

☐ **Emergency Rules** *(After completing all of Sections 1 through 3, proceed to Section 5 below)* ☒ **Regular Rules**

1. General Information

a. Agency/Board Name Wyoming Department of Health		
b. Agency/Board Address 6101 Yellowstone Road, Suite 210	c. City Cheyenne	d. Zip Code 82002
e. Name of Agency Liaison Lindsey Schilling	f. Agency Liaison Telephone Number 307-777-6032	
g. Agency Liaison Email Address lindsey.schilling@wyo.gov	h. Adoption Date August 1, 2018	
i. Program Medicaid		

2. Legislative Enactment
For purposes of this Section 2, "new" only applies to regular rules promulgated in response to a Wyoming legislative enactment not previously addressed in whole or in part by prior rulemaking and does not include rules adopted in response to a federal mandate.

a. Are these rules new as per the above description and the definition of "new" in Chapter 1 of the Rules on Rules?

☒ **No.** ☐ **Yes.** Please provide the Enrolled Act Numbers and Years Enacted:

3. Rule Type and Information

a. Provide the Chapter Number, Title, and Proposed Action for Each Chapter.
(Please use the Additional Rule Information form for more than 10 chapters and attach it to this certification)

Chapter Number:	Chapter Name:	Action
37	Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)	☐ New ☒ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed

3. State Government Notice of Intended Rulemaking

a. Date on which the Proposed Rule Packet (consisting of the Notice of Intent as per W.S. 16-3-103(a), Statement of Principal Reasons, strike and underscore format and a clean copy of each chapter of rules were: May 24, 2018

- approved as to form by the **Registrar of Rules**; and
- provided to the **Legislative Service Office** and **Attorney General:**

4. Public Notice of Intended Rulemaking

a. Notice was mailed 45 days in advance to all persons who made a timely request for advance notice. ☐ **No.** ☐ **Yes.** ■ **N/A**

b. A public hearing was held on the proposed rules. ■ **No.** ☐ **Yes. Please complete the boxes below.**

Date:	Time:	City:	Location:

c. If applicable, describe the **emergency** which requires promulgation of these rules without providing notice or an opportunity for a public hearing:

5. Final Filing of Rules

a. Date on which the Certification Page with original signatures and final rules were sent to the **Attorney General's Office for the Governor's signature**: August 1, 2018

b. Date on which final rules were approved as to form by the **Secretary of State** and sent to the Legislative Service Office: August 1, 2018

c. ■ The Statement of Reasons is attached to this certification.

6. Agency/Board Certification

The undersigned certifies that the foregoing information is correct.

Signature of Authorized Individual	Thomas O Forslund
Printed Name of Signatory	Thomas O. Forslund
Signatory Title	Director
Date of Signature	August 1, 2018

7. Governor's Certification

I have reviewed these rules and determined that they:

1. Are within the scope of the statutory authority delegated to the adopting agency;
2. Appear to be within the scope of the legislative purpose of the statutory authority; and, if emergency rules,
3. Are necessary and that I concur in the finding that they are an emergency.

Therefore, I approve the same.

Governor's Signature	
Date of Signature	

Chapter 37

Federally Qualified Health Clinics (FQHCs) and Rural Health Clinics (RHCs)

Statement of Reasons

The Wyoming Department of Health proposes to amend Chapter 37 of the Department's Medicaid Rules pursuant to its statutory authority in the Wyoming Medical Assistance and Services Act at Wyoming Statutes §§ 42-4-101 through -121. Chapter 37 governs providers, defines covered services, and establishes process for rate calculations for Federally Qualified Health Clinics (FQHCs) and Rural Health Clinics (RHCs).

The Chapter 37 Amended Rule removes the State's obligation to retroactively recover or pay out additional funds when facility rates are adjusted upon receipt of a settled Medicare cost report. The decision whether to perform retroactive adjustments is up to each state's Medicaid program. Going forward, the Department has determined that removing this obligation is more conducive to tracking expenditures and controlling the budget. Additionally, this amendment protects enrolled providers from unplanned recoveries of calculated overpayments and protects the state from unplanned reimbursement in excess of the appropriated amount.

The amendment also updates the rule's formatting and standard provisions in order to comply with current requirements.

As required by Wyoming Statute § 16-3-103(a)(i)(G), this proposed change meets minimum substantive state statutory requirements.

Chapter 37
Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

Response to Public Comment

No public comments were received during the public commenting period.

CHAPTER 37
FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) AND RURAL HEALTH CLINICS (RHC)

Section 1. Authority. This Chapter is promulgated by the Department of Health pursuant to the Medical Assistance and Services Act at Wyoming Statutes §§ 42-4-101 through -121.

Section 2. Purpose and Applicability.

(a) This Chapter has been adopted to establish Medicaid reimbursement of services provided in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), as defined in 42 U.S.C. § 1396a(bb).

(b) The requirements of Title XIX of the Social Security Act, 42 C.F.R. §§ 440.20(b) and 405.2468(f), 42 U.S.C. § 1396a(bb), and the Medicaid State Plan also apply to Medicaid and are incorporated by this reference.

Section 3. Definitions. Except as otherwise specified in Chapter 1 or as defined in this Section, the terminology used in this Chapter is the standard terminology and has the standard meaning used in healthcare, Medicaid, and Medicare.

(a) "Base period." FQHC or RHC fiscal years 1999 and 2000; if a FQHC or RHC provided services for only one (1) fiscal year, that year shall be used.

Section 4. General Methodology. Base period allowable costs are considered to be reasonable costs which are related to providing covered services during the base period as determined pursuant to 42 U.S.C. § 1396a(bb)(2). Graduate medical education costs shall be allowable costs for qualifying FQHCs and RHCs and shall be determined pursuant to 42 C.F.R. § 405.2468(f), except that the calculation shall be based on the FQHC's or RHC's Medicaid costs rather than Medicare costs.

(a) In accordance with 42 U.S.C. § 1396a(bb) the Department shall reimburse FQHCs and RHCs for covered services using a prospective payment system based on each FQHC's or RHC's base period costs, per visit, inflated forward using the Medicare economic index, and adjusted for changes in services.

Section 5. Provider Participation. In order to receive Medicaid reimbursement for furnishing services to a client, a FQHC or RHC shall be an enrolled Medicaid provider in accordance with Wyoming Medicaid Rules.

Section 6. Medicaid Allowable Payment for Services Furnished Before January 1, 2001. The Department shall reimburse for covered services provided to a

client in a FQHC or RHC using the methodology specified in the State Plan in effect as of December 31, 2000.

Section 7. Interim Medicaid Allowable Payment for Services Furnished On or After January 1, 2001, and Before October 1, 2001.

(a) Interim Medicaid allowable payment. A FQHC or RHC shall receive an interim payment pursuant to Section 6 of this Chapter.

(b) After the effective date of this Chapter, each FQHC's and RHC's Interim Medicaid allowable payment shall be retroactively adjusted to January 1, 2001, to conform to the Medicaid allowable payment determined pursuant to Section 8 of this Chapter.

Section 8. Medicaid Allowable Payment for Services Furnished On or After January 1, 2001.

(a) The Department shall reimburse for covered services provided to clients in a FQHC or RHC using a prospective payment rate determined pursuant to this Chapter.

(b) The Department shall establish a separate payment rate for each FQHC and RHC. The rate shall be determined using the base period Medicaid allowable costs, which are calculated as follows:

(i) The Department shall calculate a per visit cost for each FQHC and RHC for the FQHC's and RHC's 1999 and 2000 fiscal years. A fiscal year shall be the twelve (12) month period used by a FQHC or RHC for accounting and tax purposes. This per visit cost shall be calculated using Medicaid allowable costs from the most recently settled cost reports from those fiscal years. Visits shall be face-to-face encounters between a client and a professional staff member at a facility.

(ii) The Medicaid baseline rate (rate established using the base period for each FQHC and RHC) with 1999 and 2000 fiscal year data shall be determined by calculating a per visit rate (total allowable costs divided by total patient visits) for fiscal year 1999 and fiscal year 2000; adding the two (2) rates together; and dividing the sum by two (2).

(iii) The Medicaid baseline rate for each FQHC and RHC with only 2000 fiscal year data shall be determined by calculating a per visit rate (total allowable costs divided by total patient visits) for fiscal year 2000.

(iv) Scope of service changes for baseline rate.

(A) A FQHC or RHC which desires an adjustment to its

baseline rate due to an increase or decrease in its scope of service shall:

(I) Notify the Department, in writing, of the increase or decrease; and

(II) Provide a report, in the form and manner specified by the Department which documents the change in services and substantiates the costs associated with that change.

(B) The Department shall assess the information provided and shall determine if a rate change is warranted and the amount of any such change. Those determinations shall be based upon:

(I) The nature of the new or discontinued service regarding the type, intensity, duration, and amount of services. A change in the cost of a service is not considered in and of itself a change in the scope of services; and

(II) The reasonableness of the FQHC's or RHC's costs.

(C) The Department may request that the FQHC or RHC provide additional information to document the change in service. The information shall be provided before the Department is obligated to consider the FQHC's or RHC's request.

(v) The per visit rate calculated pursuant to Section 8(b)(ii) or (iii) of this Chapter, as adjusted for changes in scope of service pursuant to Section 8(b)(iv) of this Chapter, shall be the FQHC's or RHC's baseline rate for services provided on or after January 1, 2001, and shall be the basis for future rate determinations.

(c) The Department shall base all cost and rate calculations on a FQHC's or RHC's most recently settled cost report, unless the cost report has been submitted, but not settled. In such circumstances, the Department shall use the FQHC's or RHC's cost report as filed. If a provider or prospective provider does not participate in Medicare and does not submit a Medicare cost report, it shall submit cost information to the Department in the form and manner specified by the Department.

(i) If a cost or rate calculation is based on an as filed cost report, the Department shall recalculate the cost or rate within a reasonable time after the FQHC's or RHC's settled cost report becomes available. If the cost or rate based on an as filed cost report is different from the cost or rate calculation based on the settled cost report, the Department shall adjust the rate prospectively only and shall not retroactively reimburse the FQHC or RHC for any underpayment or recover any overpayment.

(ii) A change in a FQHC's or RHC's rate pursuant to this subsection shall not affect any averages or arrays.

(d) The Department shall re-determine each provider's Medicaid allowable payment each Federal fiscal year beginning on or after October 1, 2001, as follows:

(i) The provider's Medicaid allowable payment in effect on October 1 of each year shall be adjusted by the percentage increase in the Medicare Economic Index (MEI) as calculated using the annual data published in the fourth (4^{th}) calendar quarter in the Federal Register or posted at the CMS Health Care Indicators website (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html).

(ii) The provider's Medicaid allowable payment shall be adjusted prospectively to reflect any increase or decrease in the scope of services furnished by the FQHC or RHC during the FQHC's or RHC's fiscal year. The provisions of Section 8(b)(iv) of this Chapter shall apply to any proposed rate changes based on a change in services.

(iii) The payment established pursuant to Section 8(d) of this Chapter shall be effective for the calendar year beginning January 1 following the determination of the new rate.

Section 9. Medicaid Allowable Payment for New Providers.

(a) The Medicaid allowable payment for a provider that qualifies as a FQHC or RHC after September 30, 1999, shall be equal to one hundred percent (100%) of the reasonable costs used in calculating the rates of FQHCs or RHCs with similar caseloads located in the State during the same FQHC or RHC fiscal year. If there are no FQHCs or RHCs located in Wyoming with a similar caseload, then the Department shall calculate the rate for the new FQHC or RHC based on projected costs after applying tests of reasonableness.

(i) The FQHC or RHC shall submit a financial information worksheet, in the form and manner specified by the Department, which:

(A) In the case of an existing FQHC or RHC, reports the FQHC's or RHC's costs for its most recently completed fiscal year, the number of patient visits during that period, the services furnished to those patients, and any pending changes in services; or

(B) In the case of a new FQHC or RHC, estimates the FQHC's or RHC's cost for its next fiscal year, the number of patients the FQHC or RHC expects to serve during that period, and the services which the FQHC or RHC expects to offer during that period.

(ii) Using the information provided pursuant to Section 9(a)(i), the

Department shall establish an interim rate based on the FQHC's or RHC's reported or estimated Medicaid allowable costs.

(b) The rate determined pursuant to Section 9(a) shall remain in effect until the FQHC or RHC has submitted a cost report for one (1) FQHC or RHC fiscal year, at which time the FQHC's or RHC's rate shall be recalculated pursuant to this Chapter, except that the FQHC's or RHC's base period shall be its first (1^{st}) fiscal year during which the FQHC or RHC provided Medicaid services. The Department shall not retroactively reimburse the FQHC or RHC for any underpayment or recover any overpayment based on changes in the calculated rate.

Section 10. Medicaid Allowable Payment for Out-of-State FQHCs and RHCs.

(a) The Medicaid allowable payment for out-of-state FQHCs and RHCs shall be the statewide average Medicaid allowable payment in effect in the State as of October 1st of that year.

(b) The statewide average Medicaid allowable payment shall not be affected by a subsequent change in a FQHC's or RHC's rate.

Section 11. Third Party Liability. Third Party Liability shall be subject to the requirements of Chapter 35.

Section 12. Submission and Payment of Claims. The submission and payment of claims shall be pursuant to Chapter 3.

Section 13. Recovery of Overpayments. The Department shall recover overpayments pursuant to Chapter 16.

Section 14. Reconsideration. A provider may request reconsideration of the decision to recover overpayments pursuant to Chapter 16.

Section 15. Audits. Audits shall be subject to the provisions of Chapter 16.

Section 16. Disposition of Recovered Funds. The Department shall dispose of recovered funds pursuant to the provisions of Chapter 16.

Section 17. Interpretation of Chapter.

(a) The order in which the provisions of this Chapter 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 Chapter shall control the titles of its various provisions.

Section 18. Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Department, including manuals and bulletins, which are inconsistent with this Chapter.

Section 19. Severability. If any portion of this Chapter is found to be invalid or unenforceable, the remainder shall continue in effect.

Section 20. Incorporation by Reference.

(a) For any code, standard, rule, or regulation incorporated by reference in these rules:

(i) The Department of Health has determined that incorporation of the full text in these rules would be cumbersome or inefficient given the length or nature of the rules.

(ii) The incorporation by reference does not include any later amendments or editions of the incorporated matter beyond the applicable date identified in subsection (b) of this section; and

(iii) The incorporated code, standard, rule, or regulation is maintained at the Department of Health and is available for public inspection and copying at cost at the same location.

(b) Each item is incorporated by reference and is further identified as follows:

(i) Referenced in Section 2 of this Chapter is Title XIX of the Social Security Act, which is incorporated as of the effective date of this Chapter and can be found at https://www.ssa.gov/.

(ii) Referenced in Sections 2 and 4 of this Chapter is 42 C.F.R. § 440.20(b), which is incorporated as of the effective date of this Chapter and can be found at http://www.ecfr.gov.

(iii) Referenced in Sections 2 and 3 of this Chapter is 42 C.F.R. § 405.2468(f), which is incorporated as of the effective date of this Chapter and can be found at http://www.ecfr.gov.

(iv) Referenced in Sections 2, 3, 4 of this Chapter is 42 U.S.C. § 1396a, which is incorporated as of the effective date of this Chapter and can be found at http://uscode.house.gov/.

(v) Referenced in Section 8 of this Chapter is the Medicare Economic

Index, which is incorporated as of the effective date of this Chapter and can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html.

CHAPTER 37

~~**Rules and Regulations for Medicaid**~~

FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS) AND RURAL HEALTH CLINICS (RHCS)

Section 1. Authority. This Chapter is promulgated by the Department of Health pursuant to the Medical Assistance and Services Act at Wyoming Statutes~~.~~ § 42-4-101~~4~~ through -121.~~and the Wyoming Administrative Procedure Act at W.S. § 16-3-102.~~

Section 2. Purpose and Applicability.

(a) This Chapter has been adopted to establish Medicaid reimbursement of services provided in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), as defined in 42 U.S.C. § 1396a(bb).

(b) The requirements of Title XIX of the Social Security Act, 42 C.F.R. §§ 440.20(b) and 405.2468(f), 42 U.S.C. § 1396a(bb), and the Medicaid State Plan also apply to Medicaid and are incorporated by this reference~~., and may be cross-referenced throughout this Chapter where applicable. This incorporation by reference is effective as of the effective date of this Chapter, and does not include any later amendments or editions of the incorporated matter. The incorporated rules and regulations may be viewed at http://www.ecfr.gov/cgibin/ECFR,www.ssa.gov, and http://www.health.wyo.gov/healthcarefin/medicaid/ spa.html or may be obtained at cost from the Department.~~

Section 3. Definitions. Except as otherwise specified in Chapter 1 or as defined ~~herein~~ in this Section, the terminology used in this Chapter is the standard terminology and has the standard meaning used in healthcare, Medicaid, and Medicare.

(a) "Base period." FQHC or RHC fiscal years 1999 and 2000; if a FQHC or RHC provided services for only one (1) fiscal year, that year shall be used.

~~(b) "Base period allowable costs." Reasonable costs which are related to providing covered services during the base period as determined pursuant to 42 U.S.C. § 1396a(bb)(2). Graduate medical education costs shall be allowable costs for qualifying FQHCs and RHCs and shall be determined pursuant to 42 C.F.R. § 405.2468(f), except that the calculation shall be based on the FQHC's or RHC's Medicaid costs rather than Medicare costs.~~

Section 4. General Methodology. Base period allowable costs are considered to be reasonable costs which are related to providing covered services during the base period as determined pursuant to 42 U.S.C. § 1396a(bb)(2). Graduate medical education costs shall be allowable costs for qualifying FQHCs and RHCs and shall be determined pursuant to 42 C.F.R. § 405.2468(f), except that the calculation shall be based on the FQHC's or RHC's Medicaid costs rather than Medicare costs.

(a) In accordance with 42 U.S.C. § 1396a(bb) the Department shall reimburse FQHCs and RHCs for covered services using a prospective payment system based on each FQHC's or RHC's base period costs, per visit, inflated forward using the Medicare economic index, and adjusted for changes in services. ~~RHC services are defined by 42 C.F.R. § 440.20(b).~~

Section 5. Provider Participation. In order to receive Medicaid reimbursement for furnishing services to a client, a FQHC or RHC shall be an enrolled Medicaid provider in accordance with Wyoming Medicaid Rules.

~~(a) No FQHC or RHC, which furnishes services to a client shall receive Medicaid funds unless the FQHC or RHC is enrolled.~~

~~(a) In order to receive Medicaid reimbursement, a FQHC or RHC which wishes to receive Medicaid reimbursement for services furnished to a client shall meet the provider participation requirements of Chapter 3.~~

Section 6. Medicaid Allowable Payment for Services Furnished Before January 1, 2001. The Department shall reimburse for covered services provided to a client in a FQHC or RHC using the methodology specified in the State Plan in effect as of December 31, 2000.

Section 7. Interim Medicaid Allowable Payment for Services Furnished On or After January 1, 2001, and Before October 1, 2001.

(a) Interim Medicaid allowable payment. A FQHC or RHC shall receive an interim payment pursuant to Section 6 of this Chapter.

(b) After the effective date of this Chapter, each FQHC's and RHC's Interim Medicaid allowable payment shall be retroactively adjusted to January 1, 2001, to conform to the Medicaid allowable payment determined pursuant to Section 8 of this Chapter.

Section 8. Medicaid Allowable Payment for Services Furnished On or After January 1, 2001.

(a) The Department shall reimburse for covered services provided to clients in a FQHC or RHC using a prospective payment rate determined pursuant to this Chapter.

(b) The Department shall establish a separate payment rate for each FQHC and RHC. The rate shall be determined using the base period Medicaid allowable costs, which are calculated as follows:

(i) The Department shall calculate a per visit cost for each FQHC and RHC for the FQHC's and RHC's 1999 and 2000 fiscal years. A fiscal year shall be the twelve (12) month period used by a FQHC or RHC for accounting and tax purposes. This per visit cost shall be calculated using Medicaid allowable costs from the most recently settled cost reports from those fiscal years. Visits shall be face-to-face encounters between a client and a professional staff member at a facility.

(ii) The Medicaid baseline rate (rate established using the base period for each FQHC and RHC) with 1999 and 2000 fiscal year data shall be determined by calculating a per visit rate (total allowable costs divided by total patient visits) for fiscal year 1999 and fiscal year 2000; adding the two (2) rates together; and dividing the sum by two (2).

(iii) The Medicaid baseline rate for each FQHC and RHC with only 2000 fiscal year data shall be determined by calculating a per visit rate (total allowable costs divided by total patient visits) for fiscal year 2000.

(iv) Scope of service changes for baseline rate.

(A) A FQHC or RHC which desires an adjustment to its baseline rate due to an increase or decrease in its scope of service shall:

(I) Notify the Department, in writing, of the increase or decrease; and

(II) Provide a report, in the form and manner specified by the Department~~,~~ which documents the change in services~~,~~ and substantiates the costs associated with that change.

(B) The Department shall assess the information provided and shall determine if a rate change is warranted and the amount of any such change. Those determinations shall be based upon:

(I) The nature of the new or discontinued service regarding the type, intensity, duration, and amount of services. A change in the cost of a service is not considered in and of itself a change in the scope of services; and

(II) The reasonableness of the FQHC's or RHC's costs.

(C) The Department may request that the FQHC or RHC provide additional information to document the change in service. The information shall

be provided before the Department is obligated to consider the FQHC's or RHC's request.

(v) The per visit rate calculated pursuant to Section 8(b)(ii) or (iii) of this Chapter, as adjusted for changes in scope of service pursuant to Section 8(b)(iv) of this Chapter, shall be the FQHC's or RHC's baseline rate for services provided on or after January 1, 2001, and shall be the basis for future rate determinations.

(c) The Department shall base all cost and rate calculations on a FQHC's or RHC's most recently settled cost report, unless the cost report has been submitted, but not settled. In such circumstances, the Department shall use the FQHC's or RHC's cost report as filed. If a provider or prospective provider does not participate in Medicare and does not submit a Medicare cost report, it shall submit cost information to the Department in the form and manner specified by the Department.

(i) If a cost or rate calculation is based on an as filed cost report, the Department shall recalculate the cost or rate within a reasonable time after the FQHC's or RHC's settled cost report becomes available. If the cost or rate based on an as filed cost report is different from the cost or rate calculation based on the settled cost report, the Department shall adjust the rate prospectively only and will shall not retroactively reimburse the FQHC or RHC for any underpayment or recover any overpayment.

~~(i)~~(ii) A change in a FQHC's or RHC's rate pursuant to this subsection shall not affect any averages or arrays.

(d) The Department shall re-determine each provider's Medicaid allowable payment each Federal fiscal year beginning on or after October 1, 2001, as follows:

(i) The provider's Medicaid allowable payment in effect on October 1 of each year shall be adjusted by the percentage increase in the Medicare Economic Index (MEI) as calculated using the annual data published in the fourth (4^{th}) calendar quarter in the Federal Register or posted at the CMS Health Care Indicators website ~~(http://www.cms.gov/MedicareProgramRatesStats/04 MarketBasketData.asp).~~ (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html).

(ii) The provider's Medicaid allowable payment shall be adjusted prospectively to reflect any increase or decrease in the scope of services furnished by the FQHC or RHC during the FQHC's or RHC's fiscal year. The provisions of Section 8(b)(iv) of this Chapter shall apply to any proposed rate changes based on a change in services.

(iii) The payment established pursuant to Section 8(d) of this Chapter shall be effective for the calendar year beginning January 1 following the determination of the new rate.

Section 9. Medicaid Allowable Payment for New Providers.

(a) The Medicaid allowable payment for a provider that qualifies as a FQHC or RHC after September 30, 1999, shall be equal to one hundred percent (100%) of the reasonable costs used in calculating the rates of FQHCs or RHCs with similar caseloads located in the State during the same FQHC or RHC fiscal year. If there are no FQHCs or RHCs located in Wyoming with a similar caseload, then the Department shall calculate the rate for the new FQHC or RHC based on projected costs after applying tests of reasonableness.

(i) The FQHC or RHC shall submit a financial information worksheet, in the form and manner specified by the Department, which:

(A) In the case of an existing FQHC or RHC, reports the FQHC's or RHC's costs for its most recently completed fiscal year, the number of patient visits during that period, the services furnished to those patients, and any pending changes in services; or

(B) In the case of a new FQHC or RHC, estimates the FQHC's or RHC's cost for its next fiscal year, the number of patients the FQHC or RHC expects to serve during that period, and the services which the FQHC or RHC expects to offer during that period.

(ii) Using the information provided pursuant to Section 9(a)(i), the Department shall establish an interim rate based on the FQHC's or RHC's reported or estimated Medicaid allowable costs.

(b) The rate determined pursuant to Section 9(a) shall remain in effect until the FQHC or RHC has submitted a cost report for one (1) FQHC or RHC fiscal year, at which time the FQHC's or RHC's rate shall be recalculated pursuant to this Chapter, except that the FQHC's or RHC's base period shall be its first (1st) fiscal year during which the FQHC or RHC provided Medicaid services. The Department ~~will~~ shall not retroactively reimburse the FQHC or RHC for any underpayment or recover any overpayment based on changes in the calculated rate.

~~(i) If the Department determines the rate was unreasonably low, the Department shall retroactively reimburse the FQHC or RHC for its Medicaid allowable costs.~~

~~(ii) If the Department determines the rate was unreasonably high, the Department shall recoup the amount in excess of the FQHC's or RHC's Medicaid allowable costs.~~

Section 10. Medicaid Allowable Payment for Out-of-State FQHCs and RHCs.

(a) The Medicaid allowable payment for out-of-state FQHCs and RHCs shall be the statewide average Medicaid allowable payment in effect in the State as of October 1st of that year.

(b) The statewide average Medicaid allowable payment shall not be affected by a subsequent change in a FQHC's or RHC's rate.

Section 11. Third Party Liability. Third Party Liability shall be subject to the requirements of Chapter 35.

Section 12. Submission and Payment of Claims. The submission and payment of claims shall be pursuant to Chapter 3.

Section 13. Recovery of Overpayments. The Department shall recover overpayments pursuant to Chapter 16.

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Section 15. Audits. Audits shall be subject to the provisions of Chapter 16.

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(a) The order in which the provisions of this Chapter appear is not to be construed to mean that any one provision is more or less important than any other provision.

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Section 18. Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Department, including manuals and bulletins, which are inconsistent with this Chapter.

Section 19. Severability. If any portion of this Chapter is found to be invalid or unenforceable, the remainder shall continue in effect.

Section 20. Incorporation by Reference.

(a) For any code, standard, rule, or regulation incorporated by reference in these rules:

(i) The Department of Health has determined that incorporation of the full text in these rules would be cumbersome or inefficient given the length or nature of the rules.

(ii) The incorporation by reference does not include any later amendments or editions of the incorporated matter beyond the applicable date identified in subsection (b) of this section; and

(iii) The incorporated code, standard, rule, or regulation is maintained at the Department of Health and is available for public inspection and copying at cost at the same location.

(b) Each item is incorporated by reference and is further identified as follows:

(i) Referenced in Section 2 of this Chapter is Title XIX of the Social Security Act, which is incorporated as of the effective date of this Chapter and can be found at https://www.ssa.gov/.

(ii) Referenced in Sections 2 and 4 of this Chapter is 42 C.F.R. § 440.20(b), which is incorporated as of the effective date of this Chapter and can be found at http://www.ecfr.gov.

(iii) Referenced in Sections 2 and 3 of this Chapter is 42 C.F.R. § 405.2468(f), which is incorporated as of the effective date of this Chapter and can be found at http://www.ecfr.gov.

(iv) Referenced in Sections 2, 3, 4 of this Chapter is 42 U.S.C. § 1396a, which is incorporated as of the effective date of this Chapter and can be found at http://uscode.house.gov/.

(v) Referenced in Section 8 of this Chapter is the Medicare Economic Index, which is incorporated as of the effective date of this Chapter and can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html.