Certification Page
Regular and Emergency Rules

Revised June 2020

☐ **Emergency Rules** *(Complete Sections 1-3 and 5-6)* ■ **Regular Rules**

1. General Information

a. Agency/Board Name* Wyoming Department of Health		
b. Agency/Board Address 401 Hathaway Building, 2300 Capitol Ave.	c. City Cheyenne	d. Zip Code 82002
e. Name of Agency Liaison Lindsay Mills	f. Agency Liaison Telephone Number 307-777-8622	
g. Agency Liaison Email Address lindsay.mills@wyo.gov	h. Adoption Date June 8, 2023	
i. Program Medicaid		
Amended Program Name (*if applicable*):		

* ☐ *By checking this box, the agency is indicating it is exempt from certain sections of the Administrative Procedure Act including public comment period requirements. Please contact the agency for details regarding these rules.*

2. Legislative Enactment

For purposes of this Section 2, "new" only applies to regular (non-emergency) 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 non-emergency or regular rules new as per the above description and the definition of "new" in Chapter 1 of the Rules on Rules?

■ **No.** ☐ **Yes.** If the rules are new, please provide the Legislative Chapter Numbers and Years Enacted (e.g. 2015 Session Laws Chapter 154):

3. Rule Type and Information

For purposes of this Section 3, "New" means an emergency or regular rule that has never been previously created.

a. Provide the Chapter Number, Title* and Proposed Action for Each Chapter. *Please use the "Additional Rule Information" form to identify additional rule chapters.*

Chapter Number:	Chapter Name:	New	Amended	Repealed
thirty-seven (37)	FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS	☐	■	☐
	Amended Chapter Name (*if applicable*):			
Chapter Number:	Chapter Name:	☐	☐	☐
	Amended Chapter Name (*if applicable*):			
Chapter Number:	Chapter Name:	☐	☐	☐
	Amended Chapter Name (*if applicable*):			
Chapter Number:	Chapter Name:	☐	☐	☐
	Amended Chapter Name (*if applicable*):			
Chapter Number:	Chapter Name:	☐	☐	☐
	Amended Chapter Name (*if applicable*):			
Chapter Number:	Chapter Name:	☐	☐	☐
	Amended Chapter Name (*if applicable*):			

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:

5. Checklist

a. ☑ For regular rules, the Statement of Principal Reasons is attached to this Certification and, in compliance with Tri-State Generation and Transmission Association, Inc. v. Environmental Quality Council, 590 P.2d 1324 (Wyo. 1979), includes a brief statement of the substance or terms of the rule and the basis and purpose of the rule

b. ☐ For emergency rules, the Memorandum to the Governor documenting the emergency, which requires promulgation of these rules without providing notice or an opportunity for a public hearing, is attached to this Certification.

6. Agency/Board Certification

The undersigned certifies that the foregoing information is correct. By electronically submitting the emergency or regular rules into the Wyoming Administrative Rules System, the undersigned acknowledges that the Registrar of Rules will review the rules as to form and, if approved, the electronic filing system will electronically notify the Governor's Office, Attorney General's Office, and Legislative Service Office of the approval and electronically provide them with a copy of the complete rule packet on the date approved by the Registrar of Rules. The complete rules packet includes this signed certification page; the Statement of Principal Reasons or, if emergency rules, the Memorandum to the Governor documenting the emergency; and a strike and underscore copy and clean copy of each chapter of rules.

Signature of Authorized Individual	
Printed Name of Signatory	Stefan Johansson
Signatory Title	Director
Date of Signature	6/8/23

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	

MEDICAID

Amendment of Chapter 37

FEDERALLY QUALIFIED HEALTH CENTERS AND
RURAL HEALTH CLINICS

SUMMARY OF COMMENTS

The Wyoming Department of Health did not receive any public comments.

Wyoming Medicaid Rules

Chapter 37

Federally Qualified Health Centers and Rural Health Clinics

Intent to Adopt Amended Rule

Statement of Reasons

The Wyoming Department of Health proposes to adopt the following Amended Rule pursuant to its statutory authority in Wyoming Statutes §§ 42-4-101 through -124.

Chapter 37 establishes and governs the provision of and reimbursement of services provided to clients at federally qualified health centers (FQHCs) or rural health clinics (RHCs) and shall apply to payment and submission of claim by all providers of such services.

The proposed amendment is intended to describe the services covered and update the general reimbursement methodology for FQHCs and RHC's specifically for interim rates and for new providers. Lastly, the proposed amendment generally updates the incorporation by reference sections and formatting 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 AND RURAL HEALTH CLINICS

Section 1. Authority.

(a) The Wyoming Department of Health (Department) promulgates this Chapter pursuant to the Medical Assistance and Services Act at Wyoming Statutes 42-4-101 through -124.

Section 2. Purpose and Applicability.

(a) The Department adopts this Chapter to establish the Wyoming Medicaid requirements and reimbursement for services provided in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), as defined in 42 U.S.C. § 1396d(l)(2).

(b) This Chapter applies to all clients and providers for all Medicaid-covered services furnished in FQHCs and RHCs.

(c) The Department may issue manuals and bulletins to interpret this Chapter. Such manuals and bulletins shall be consistent with and reflect the rules contained in this Chapter. The provisions contained in manuals or bulletins shall be subordinate to this Chapter.

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

(a) "Base period" means 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 as the "base period."

(b) "Medicare Economic Index (MEI)" means the measure of practice cost inflation used to estimate annual changes in physicians' operating costs and earnings levels.

(c) "Visit" means a face-to-face encounter between a FQHC or RHC client and a FQHC or RHC professional staff member for the purpose of providing FQHC or RHC services. Telehealth visits are considered face-to-face visits.

Section 4. Provider Enrollment and Participation. In order to receive Medicaid reimbursement for furnishing services to a client, a FQHC or RHC shall be an enrolled Medicaid provider and in compliance with requirements for Medicaid participation in accordance with Wyoming Medicaid Rules Chapter 3.

Section 5. Reimbursable Services.

(a) FQHC and RHC reimbursable services are outpatient services that occur during an eligible visit and include:

(i) Physician services;
(ii) Nurse practitioner, physician's assistant, and certified nurse midwife services;
(iii) Behavioral health services provided pursuant to Wyoming Medicaid Rules Chapter 13 by providers licensed to provide such services;

(iv) Preventive primary care services;
(v) Dental services;
(vi) Vision services;
(vii) Audiology services;

(b) The following services and supplies furnished as incidental to the provider's services are included in the provider's rate and are not billable as a stand-alone visit, even if the service is performed on a separate day from the original visit:

(i) Lab services;
(ii) Drugs and biologicals that cannot be self-administered;
(iii) Supplies;
(iv) Radiology;
(v) Diagnostic services;
(vi) Therapeutic services;
(vii) Outreach;
(viii) Case management;
(ix) Transportation;

(c) If services are furnished at a permanent site in more than one location, each site will be independently considered for approval as a provider, unless prior approval was granted by CMS to operate both locations under a single provider number. To be considered a satellite provider location both sites must share medical staff, office staff, and/or administrative staff.

Section 6. General Reimbursement Methodology.

(a) 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.

(b) 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 for that calendar year, per visit, inflated forward using the MEI, and adjusted for changes in services.

Section 7. 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.

(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 years 1999 and 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) An 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) Submit a settled Medicare Cost Report 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 this Section, as adjusted for changes in scope of service pursuant to this Section, 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.

(vi) For any FQHC or RHC that was not in operation during 1999 or 2000 fiscal years, refer to Section 7.

(c) The Department shall base all cost and rate calculations on a FQHC's or RHC's most recently settled Medicare Cost Report. If a settled Medicare Cost Report is not available, the Department shall use the FQHC's or RHC's Medicare Cost Report as filed.

(i) If a cost or rate calculation is based on an "as filed" Medicare 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 only adjust the rate prospectively 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.

(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 MEI as calculated using the annual data published in the fourth (4th) calendar quarter in the Federal Register or posted at the CMS Health Care Indicators website at https://www.cms.gov on the Market Basket Data updates page.

(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 (b)(iv) shall apply to any proposed rate changes based on a change in services.

(iii) The payment established pursuant to Section 7(d) of this Chapter shall be effective for the calendar year beginning January 1 following the determination of the new rate.

Section 8. Medicaid Allowable Payment for New Providers.

(a) A provider that qualifies as a FQHC or RHC after September 30, 1999, must submit a settled or "as filed" Medicare Cost Report to the Department, which will serve as the basis for the provider's rate calculation. Upon submission of a settled or an "as filed" Medicare Cost Report a visit rate will be calculated as described by the cost formula in Section 7.

(b) If the FQHC or RHC does not have a settled or an "as filed" Medicare Cost Report, the provider shall submit cost information to the Department for services previously provided indicating estimates for its next fiscal year and the number of patients and services it expects to offer during that period.

(c) The Medicaid allowable payment for a new provider shall be an interim visit rate equal to one hundred (100) percent of the reasonable costs used in calculating the rates of FQHCs or RHCs with similar caseloads located in the state during the same facility fiscal year, adjusted by the percentage increase in MEI, as described by the cost formula in Section 7. Interim visit rates will be specific to each provider type: Independent RHCs, Hospital-based RHCs, and FQHCs.

(i) If there are no FQHCs or RHC's with similar caseloads, the Medicaid allowable payment for a new provider shall be an interim visit rate equal to the Medicaid statewide average visit rate for the calendar year, adjusted by the percentage increase in MEI, as described by the cost formula in Section 7. Interim visit rates will be specific to each provider type: Independent RHCs, Hospital-based RHCs, and FQHCs.

(d) The interim rate determined pursuant to subsection (c) shall remain in effect until the FQHC or RHC has submitted a settled Medicare Cost Report, at which time the FQHC's or RHC's rate shall be recalculated pursuant to Section 7, except that the new FQHC's or RHC's base period shall be its first 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 9. 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 Wyoming 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.

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

Section 1. Authority.

a) ~~This Chapter is promulgated by the~~ The Wyoming Department of Health (Department) promulgates this Chapter pursuant to the Medical Assistance and Services Act at Wyoming Statutes §§42-4-101 through -12~~14~~.

Section 2. Purpose and Applicability.

(a) ~~This Chapter~~ The Department ~~has been~~ adopts~~ed~~ this Chapter to establish the Wyoming Medicaid requirements and reimbursement ~~of~~ for services provided in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), as defined in 42 U.S.C. § 1396~~a(bb).~~ d(1)(2).

(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.~~ This Chapter applies to all clients and providers for all Medicaid-covered services furnished in FQHCs and RHCs.

(c) The Department may issue manuals and bulletins to interpret this Chapter. Such manuals and bulletins shall be consistent with and reflect the rules contained in this Chapter. The provisions contained in manuals or bulletins shall be subordinate to this Chapter.

Section 3. Definitions. Except as otherwise specified in Wyoming Medicaid Rules 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." means 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 as the "base period."

(b) "Medicare Economic Index (MEI)" means the measure of practice cost inflation used to estimate annual changes in physicians' operating costs and earnings levels.

(c) "Visit" means a face-to-face encounter between a FQHC or RHC client and a FQHC or RHC professional staff member for the purpose of providing FQHC or RHC services. Telehealth visits are considered face-to-face visits.

~~**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 4. **Provider Enrollment and Participation.** In order to receive Medicaid reimbursement for furnishing services to a client, a FQHC or RHC shall be an enrolled Medicaid provider and in compliance with requirements for Medicaid participation in accordance with Wyoming Medicaid Rules Chapter 3.

~~**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 5. Reimbursable Services.

(a) FQHC and RHC reimbursable services are outpatient services that occur during an eligible visit and include:

(i) Physician services;
(ii) Nurse practitioner, physician's assistant, and certified nurse midwife services;
(iii) Behavioral health services provided pursuant to Wyoming Medicaid Rules Chapter 13 by providers licensed to provide such services;
(iv) Preventive primary care services;
(v) Dental services;
(vi) Vision services;
(vii) Audiology services;

(b) The following services and supplies furnished as incidental to the provider's services are included in the provider's rate and are not billable as a stand-alone visit, even if the service is performed on a separate day from the original visit:

(i) Lab services;
(ii) Drugs and biologicals that cannot be self-administered;
(iii) Supplies;
(iv) Radiology;
(v) Diagnostic services;
(vi) Therapeutic services;
(vii) Outreach;
(viii) Case management;
(ix) Transportation;

(c) If services are furnished at a permanent site in more than one location, each site will be independently considered for approval as a provider, unless prior approval was granted by CMS to operate both locations under a single provider number. To be considered a satellite provider location both sites must share medical staff, office staff, and/or administrative staff.

~~**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 6. General Reimbursement Methodology.

(a) 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.

(b) 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 for that calendar year, per visit, inflated forward using the MEI, and adjusted for changes in services.

~~**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. 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) 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 7. 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 fiscal year data shall be determined by calculating a per visit rate (total allowable costs divided by total patient visits) for fiscal year.

(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) Submit a settled Medicare Cost Report ~~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 6(b)(ii) or (iii) of this Chapter, as adjusted for changes in scope of service pursuant to Section 6(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.

(vi) For any FQHC or RHC that was not in operation during 1999 or 2000 fiscal years, refer to Section 8.

(c) The Department shall base all cost and rate calculations on a FQHC's or RHC's most recently settled Medicare eCost rReport,. ~~unless the cost report has been submitted, but not settled. In such circumstances~~, If a settled cost report is not available, 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" Medicare eCost rReport, 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 (4th) calendar quarter in the Federal Register or posted at the CMS Health Care Indicators website at ~~(https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html).~~ https://www.cms.gov on the Market Basket Data updates page.

(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 subs~~S~~ection ~~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 7~~8~~(d) of this Chapter shall be effective for the calendar year beginning January 1 following the determination of the new rate.

Section 8 ~~9~~. Medicaid Allowable Payment for New Providers.

(a) ~~The Medicaid allowable payment for a~~ A provider that qualifies as a FQHC or RHC after September 30, 1999, shall submit a settled or an "as filed" Medicare Cost Report to the Department, which will serve as the basis for the provider's rate calculation. Upon submission of a settled or an "as filed" Medicare Cost Report a rate will be calculated as described by the cost formula in Section 7. ~~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) If the new FQHC or RHC does not yet have a settled or an "as filed" Medicare Cost Report, the provider shall submit cost information to the Department for services previously provided, or expected to be provided, indicating estimates for its next fiscal year and the number of patients and services it expects to offer during that period.

(c) Using the information provided, the Department shall establish an interim per visit rate based on the FQHC's or RHC's reported or estimated Medicaid allowable costs.

(d) The Medicaid allowable payment for a new provider shall be an interim per visit rate equal to one hundred (100) percent of the reasonable costs used in calculating the rates of FQHCs or RHCs with similar caseloads located in the state during the same facility fiscal year, adjusted by the percentage increase in MEI, as described by the cost formula in Section 7. Interim rates will be specific to each provider type: Independent RHCs, Hospital-based RHCs, and FQHCs.

(i) If there are no FQHCs or RHC's with similar caseloads, the Medicaid allowable payment for a new provider shall be an interim per visit rate equal to the Medicaid statewide average per visit rate for the calendar year, adjusted by the percentage increase in MEI, as described by the cost formula in Section 7. Interim visit rates will be specific to each provider type: Independent RHCs, Hospital-based RHCs, and FQHCs.

~~(b)~~(e) The interim rate determined pursuant to subs~~S~~ection ~~9(a)~~ (c) shall remain in effect until the FQHC or RHC has submitted a settled or an "as filed" Medicare ~~c~~Cost ~~r~~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~~ Section 7, 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 shall not retroactively reimburse the FQHC or RHC for any underpayment or recover any overpayment based on changes in the calculated rate.

Section 9~~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.