State of Wyoming

Department of Health

Rules and Regulations for Kid Care CHIP ("Children's Health Insurance Program")

Brent D. Sherard, M.D., M.P.H., F.A.C.P.
Director and State Health Officer

June 2010

State of Wyoming

Department of Health

Rules and Regulations for Kid Care CHIP ("Children's Health Insurance Program")

Brent D. Sherard, M.D., M.P.H., F.A.C.P.
Director and State Health Officer

~~**July 2009**~~ **June 2010**

State of Wyoming
Department of Health

Chapters ~~1 through 4~~ 1, 3 and 4
Rules and Regulations for Kid Care CHIP
("Children's Health Insurance Program")

Rules and Regulations for Kid Care CHIP
("Children's Health Insurance Program")
Wyoming Department of Health
Office of Healthcare Financing

Additional information and copies may be obtained from:
Patricia Guzman
Kid Care CHIP
6101 Yellowstone Rd., Ste. 210
Cheyenne, WY 82002
Phone: (307) 777-6228
Fax: (307) 777-7085
E-Mail: patricia.guzman@health.wyo.gov

This document is available in alternative format upon request.

CHAPTER 1
Rules for General Provisions

Section 1. Authority 1-1
Section 2. Purpose and Applicability 1-1
Section 3. General Provisions 1-1
Section 4. Definitions 1-1
Section 5. Payments Only to Participating Insurance Companies 1-11
Section 6. Participating Insurance Company ..... 1-~~11~~ 12
Section 7. Insurance Contractor 1-12
Section 8. Safeguarding Information ..... 1-~~12~~ 13
Section 9. Payment and Submission of Invoices ..... 1-~~12~~ 13
Section 10. Recovery of Excess Payments ..... 1-~~12~~ 13
Section 11. Recovery of Overpayments 1-13
Section 12. Reconsideration and Contested Cases 1-13
Section 13. Disposition of Recovered Funds ..... 1-~~13~~ 14
Section 14. Contingent on Funding ..... 1-~~13~~ 14
Section 15. Financial Audits ..... 1-~~14~~ 15
Section 16. Interpretation of Chapter ..... 1-~~14~~ 15
Section 17. Superseding Effect ..... 1-~~14~~ 15
Section 18. Severability 1-15

CHAPTER 3
Rules for Benefits

Section 1. Authority 3-1
Section 2. Purpose and Applicability 3-1
Section 3. Health Benefits Plan Committee 3-1
Section 4. Basic Level of Benefits 3-1

CHAPTER 4
Rules for Cost Sharing

Section 1. Authority 4-1
Section 2. Purpose and Applicability 4-1
Section 3. Cost Sharing Maximums 4-1
Section 4. Co-payments 4-1
Section 5. Exclusions from Co-payments 4-3

CHAPTER 1

Rules and Regulations for Kid Care CHIP ("Children's Health Insurance Program")

General Provisions

Section 1. Authority. This Chapter is promulgated by the Department of Health pursuant to the Child Health Insurance Program Act at W.S. §§ 35-25-101 through 35-25-111 and the Wyoming Administrative Procedure Act at W.S. § 16-3-101, *et seq.*

Section 2. Purpose and Applicability.

(a) This Chapter shall apply to and govern Kid Care CHIP. This Chapter shall become effective for Kid Care CHIP services provided on or after October 1, 2009.

(b) The Department may issue manuals, bulletins, or both to interpret the provision of this Chapter. Such manuals and bulletins shall be consistent with and reflect the policies contained in this Chapter. The provisions contained in manuals or bulletins shall be subordinate to the provisions of this Chapter.

Section 3. General Provisions.

(a) This Chapter is intended to be read in conjunction with the Child Health Insurance Program Act at W.S. §§ 35-25-101 through 35-25-111, Chapter 7 of Sub-chapter XXI of the Social Security Act codified at 42 U.S.C § 1397aa through 1397jj, and HHS Regulations at 42 C.F.R Part 457.

(b) In accordance with 42 U.S.C § 1397bb(b)(4), nothing in this Chapter shall be construed as providing an individual with an entitlement to Kid Care CHIP.

(c) The incorporation by reference of any external standard is intended to be the incorporation of that standard as it is in effect on the effective date of this Chapter.

Section 4. Definitions. The following definitions shall apply in the interpretation and enforcement of these rules. Where the context in which words are used in these rules indicates that such is the intent, words in the singular number shall include the plural and visa-versa. Throughout these rules gender pronouns are used interchangeably except where the context dictates otherwise. The drafters have attempted to utilize each gender pronoun in equal numbers in random distribution. Words in each gender shall include individuals of the other gender. Except as otherwise specified in this section, the terminology used in this Chapter is the standard terminology and has the standard meaning used in health care, health insurance, Medicare, and Medicaid.

For the purposes of these rules, the following shall apply:

(a) "Absent parent" shall mean any parent who is not providing care and control of the child or who cannot be counted on to function in the planning for the physical care, guidance, and maintenance of the child.

(b) "Act" shall mean the "Child Health Insurance Program Act," as enacted by the Wyoming Legislature and codified at W.S. §§ 35-25-101 through 35-25-111.

(c) "Adverse action" shall mean the denial, suspension, or termination of benefits, other than a suspension or termination caused by a suspension of Kid Care CHIP, pursuant to Section 14 or a change in Federal or State law, including an amendment to this Chapter. "Adverse action" does not include the denial of services because they are not covered services or other issues about the scope of covered services.

(d) "Alaska Native" shall mean an Eskimo, Aleut, or other Alaska Native enrolled by the United States Secretary of the Interior.

(e) "Alien" shall mean a person residing in Wyoming who is not a citizen of the United States of America.

(f) "American Indian" shall mean a person who is an enrolled member of a federally recognized Indian tribe, band, or group, or a first or second degree descendent of such person.

(g) "Applicant" shall mean a child on whose behalf an application for coverage by Kid Care CHIP has been submitted, but there has been no final determination of eligibility.

(h) "Application" shall mean the form, specified by the Department, on which an applicant indicates in writing the desire to receive benefits.

(i) "Application date" shall mean the date an application for Kid Care CHIP is received and date stamped by the Department.

(j) "Approve" shall mean to determine an applicant is eligible for Kid Care CHIP benefits.

(k) "Basis level of benefits" shall mean the level of benefits established by the Health Benefits Plan Committee pursuant to Chapter 3.

(l) "Benefits" shall mean the insurance coverage through Kid Care CHIP.

(m) "Benefit year" shall mean January to December of each year, so long as the insured remains eligible.

(n) "Biennium" shall mean the period covering two (2) State fiscal years following each regularly scheduled budget session of the Wyoming Legislature.

(o) "Caretaker" shall mean a person who is the physical custodian of a child.

(p) "Change in circumstances" shall mean a change in an insured's address or health insurance coverage.

(q) "Change report" shall mean a form, as prescribed by the Department, used to report a change in circumstances.

(r) "Chapter 1 of the Medicaid rules" shall mean Chapter 1, Medicaid Fair Hearings, of the Wyoming Medicaid rules.

(s) "Chapter 16 of the Medicaid rules" shall mean Chapter 16, Medicaid and State Funded Program Integrity, of the Wyoming Medicaid rules.

(t) "Chapter 38 of the Medicaid rules" shall mean Chapter 38, Safeguarding Information on Applicants and Recipients, of the Wyoming Medicaid rules.

(u) "Chapter 39 of the Medicaid rules" shall mean Chapter 39, Recovery of Excess Payments, of the Wyoming Medicaid rules.

(v) "Child" shall mean a person who is less than nineteen (19) years of age.

(w) "Citizen" shall mean an individual who is a citizen or the dependent of a citizen of the United States of America.

(x) "Centers for Medicare and Medicaid Services (CMS)" shall mean the federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program.

(y) "Contested case" as defined in Chapter 1 of the Medicaid rules, which definition is incorporated by this reference.

(z) "Cost sharing or co-payment" shall be a charge to an insured for receiving services covered under a health insurance plan.

(aa) "Countable income" shall mean income, including earned income, unearned income, and in-kind income, which is used to determined program eligibility. "Countable income" does not include exempt income.

(bb) "Cost-effective" shall mean the cost of providing program benefits does not exceed the average cost of similar programs in similar states, available state funds, or both.

(cc) "Covered services" shall mean those health services which are covered by a health insurance plan offered pursuant to Chapter 3. "Covered services" must include the basic level of benefits.

(dd) "Crowd out" shall mean the replacement or elimination of insurance by benefits offered pursuant to this Chapter.

(ee) "Department" shall mean the Wyoming Department of Health, its agent, designee, or successor.

(ff) "Dependent" shall mean one who relies on another for financial support.

(gg) "Dental medical necessity" shall mean that a covered service, in a manner consistent with accepted standards of medical practice, is:

(i) Consistent with the symptom, diagnosis and treatment of an insured's medical conditions;

(ii) Widely accepted by the practitioner's peer group as efficacious and reasonably safe based upon scientific evidence;

(iii) Not experimental, investigational, unproven, unusual or non-customary;

(iv) Not solely for cosmetic purposes;

(v) Not solely for the convenience of the insured, subscriber physician or other provider;

(vi) An appropriate level of care that can be safely provided to the insured, and failure to provide the covered service would adversely affect the insured's health;

(vii) When applied to inpatient care, further means that covered services cannot be safely provided in an ambulatory setting.

(hh) "Effective date of eligibility" shall mean a child found eligible for Kid Care CHIP whose application was received on or before the twenty-fifth (25th) day of the month will be covered for services as of the first (1st) day of the following month. If an application is received after the twenty-fifth (25th) day of the month, the child will be covered for services as of the first (1st) day of the month after the following month.

(ii) "Eligible" shall mean a person who is approved for Kid Care CHIP.

(jj) "Eligible child" shall mean a low income child who:

(i) Has not been covered by a health insurance plan for one (1) month or more before the date of application (unless the child loses health insurance through no fault of her own); or

(ii) Upon birth is not covered by a public or private health insurance plan; and who is not eligible for state employee dependent coverage; and

(iii) Is not in a public institution;

(iv) Is a U.S. resident or qualified alien;

(v) Is not eligible for Medicaid;

(vi) Has not yet reached his nineteenth (19^{th}) birthday;

(vii) Has not reached his lifetime maximum.

(kk) "Excess payments" shall mean Kid Care CHIP funds received by a participating insurance company to which the company is not entitled for any reason. "Excess payments" includes, but is not limited to:

(i) Overpayments;

(ii) Payments made as a result of system errors;

(iii) Payments for premiums or services furnished to a non-insured;

(iv) Payments for non-covered services furnished to an insured; or

(v) Payments which exceed the contract rate agreed to by the participating insurance company.

(ll) "Explanation of benefits form (EOB)" shall mean a form sent by the insurance contractor to both providers of a service and the enrolled child. EOBs provide information, claim payment, and client responsibility.

(mm) "Family" shall mean one or more children residing in the same household with one or both natural parents, adoptive parents, a guardian, or a caretaker.

(nn) "Federal funds" shall mean the Federal funds received by the Department pursuant to 42 U.S.C.A. § 1397ee to pay for Kid Care CHIP costs.

(oo) "Federal poverty level (FPL)" shall mean the poverty guideline updated annually in the Federal Register by HHS under the authority of Section 673(2) of the Omnibus Reconciliation Act of 1981.

(pp) "Financially responsible adult" shall mean the person or persons legally responsible to support one or more low income children. "Financially responsible adult" may include a caretaker.

(qq) "Financial records" shall mean all records, in whatever form, used or maintained by a participating insurance company in the conduct of its business affairs and which are necessary to substantiate or understand invoices submitted to the Department.

(rr) "Guardian" shall mean a child's legally appointed conservator or guardian.

(ss) "Health benefits plan committee" shall mean the committee appointed pursuant to W.S. §§ 35-25-105 to establish the basic level of benefits.

(tt) "Health insurance plan" shall mean an individual insurance policy or contract for the purpose of paying for or reimbursing the cost of hospital and medical care. "Health insurance plan" includes private insurance plans.

(uu) "HHS" shall mean the United States Department of Health and Human Services, its agent, designee, or successor.

(vv) "Household" shall mean the person or persons who live together in a residence. A "household" may include one or more families.

(ww) "Illegal alien" shall mean a foreign national who:

(i) Entered the U.S. without inspection or with fraudulent documentation; or

(ii) After entering legally as a nonimmigrant, violated status and remained in the U.S. without permission.

(xx) "Income" shall mean gross earned income, unearned income, or in-kind payments received from any source, excluding money classified as a resource or exempt income:

(i) Earned income includes:

(A) Any payment received by an employee or agent in cash or in-kind as wages, salary, tips, commissions, or pursuant to a contract.

(B) Net profits received from activities in which the individual is engaged (self-employment). "Net profits" means the total sum after deductions for personal or employment expenses and excludes the meal allowance used by the Federal

Insurance Contribution Act (FICA). A family may deduct twenty-five percent (25%) of its gross self-employment income or it may deduct actual business expenses; however, depreciation may not be deducted.

(ii) Exempt income is money set aside or free from program policy limits and not counted against program income limits. The following income is exempt:

(A) Income which is required to be excluded under a federal statute;

(B) Unearned income paid in-kind to a household member, such as payment made to a third party for food, shelter, clothing, or other needs;

(C) Educational income, such as grants, scholarships, fellowships, education loans, and work-study income paid to a person who is enrolled in an educational program. Educational income received in excess of education expenses is not exempt;

(D) Needs-based veterans' benefits;

(E) Reimbursement for expenses incurred by the individual; and

(F) Child care assistance paid under Title XX of the Social Security Act.

(yy) "Ineligible" shall mean not authorized to be an insured under Kid Care CHIP.

(zz) "Inmate of a public institution" as defined in 42 C.F.R. § 435.1009, which definition is incorporated by this reference.

(aaa) "Institute for mental disease" as defined in 42 C.F.R. § 435.1009, which definition is incorporated by this reference.

(bbb) "Insured" shall mean a low income child who has been determined eligible for Kid Care CHIP.

(ccc) "Invoice" shall mean a request by a participating insurance company for payment of Kid Care CHIP funds for insurance premiums.

(ddd) "Kid Care CHIP" shall mean the Children's Health Insurance Program established pursuant to the Child Health Insurance Program Act, W.S. §§ 32-25-101 through 35-25-111.

(eee) "Kid Care CHIP funds" shall mean that combination of Federal funds and State funds which is available to the Department to make payments to participating insurance companies for insurance coverage furnished to eligible children.

(fff) "Kid Care CHIP state plan" shall mean the state plan prepared by the Department pursuant to 42 U.S.C. § 1397aa(b) and submitted to HHS.

(ggg) "Low-income child" shall mean a child whose family's gross monthly income as determined pursuant to Chapter 2 is not more than two hundred percent (200%) of the federal poverty level.

(hhh) "Medicaid" shall mean medical assistance and services provided pursuant to Title XIX of the Social Security Act or the Wyoming Medical Assistance and Services Act of 1967, as amended. "Medicaid" includes any successor or replacement program enacted by Congress or the Wyoming Legislature. "Medicaid" in Wyoming is also called "EqualityCare."

(iii) "Medically necessary" or "medical necessity" shall mean a health service that is required to diagnose, treat, cure, or prevent an illness, injury, or disease which has been diagnosed or is reasonably suspected; to relieve pain; or to improve and preserve health and be essential to life. The service must be:

(i) Consistent with the diagnoses and treatment of the insured's condition;

(ii) In accordance with the standards of good medical practice among the provider's peer group;

(iii) Required to meet the medical needs of the insured and undertaken for reasons other than the convenience of the insured and the provider; and

(iv) Performed in the most cost effective and appropriate setting required by the insured's condition.

(jjj) "Medical records" shall mean all records, in whatever form, in the possession of or subject to the control of a participating insurance company which describes the insured's diagnosis, treatment, or condition.

(kkk) "Mid-level practitioner" shall mean a physician's assistant, a certified nurse practitioner, a certified nurse midwife, or any other licensed health care professional authorized to diagnose and treat patients.

(lll) "Month" shall mean a calendar month.

(mmm)"Notice of action" shall mean a written notice mailed to an insured which informs the insured of intended action affecting eligibility for benefits. The notice shall include the action to be taken, the effective date of the action, and the legal authority for the action. Notice shall be timely if mailed, by first-class United States mail, ten (10) days before the effective date of the intended action.

(nnn) "Orthodontia medical necessity" shall mean medically necessary orthodontic services or cranial facial orthopedic deformities with an evaluation report from an orthodontist. This benefit is not available for patients currently under treatment in another State run program or through a private pay arrangement. Orthodontia medical necessity shall be determined by the dental contractor's orthodontic consultant.

(ooo) "Out of pocket maximum" shall mean the most money in cost sharing that a household will have to pay in a given benefit year. This amount is capped at five percent (5%) of the household's gross annual income. Once the out of pocket maximum has been met, the family will not pay any more cost sharing until the next benefit year begins.

(ppp) "Overpayments" shall mean Kid Care CHIP funds received by a participating insurance company as the result of fraud or abuse, as those terms are defined in Chapter 16 of the Medicaid rules, which definitions are incorporated by this reference.

(qqq) "Participating insurance company" shall mean an insurance company which has contracted with the Department to provide benefits to eligible children.

(rrr) "Periodic review" shall mean a review of an insured's eligibility. A "periodic review" shall be conducted every twelve (12) months after the effective date of eligibility.

(sss) "Plan A" shall mean the Kid Care CHIP plan that includes Native American children, Alaskan Native children, and those children whose family income is one hundred percent (100%) or lower of the federal poverty level.

(ttt) "Plan B" shall mean the Kid Care CHIP plan that includes children from one hundred one percent (101%) to one hundred fifty percent (150%) of the federal poverty level.

(uuu) "Plan C" shall mean the Kid Care CHIP plan that includes children from one hundred fifty one percent (151%) to two hundred percent (200%) of the federal poverty level.

(vvv) "Practitioner" shall mean a physician, nurse practitioner, dentist, optometrist, or any other health care professional acting within the scope of her practice.

(www) "Pre-existing condition" shall mean an illness, injury, or health condition which exists as of the application date.

(xxx) "Premium" shall mean the payment necessary to pay for a health insurance plan provided to an eligible child.

(yyy) "Private insurance plan" shall mean a health insurance plan which is not an employer-based plan.

(zzz) "Program" shall mean Kid Care CHIP.

(aaaa) "Provider" shall mean an individual or entity that has an agreement with a participating insurance company to furnish services to an insured.

(bbbb) "Qualified alien" shall mean a lawfully admitted alien who qualifies if he:

(i) Is admitted to the United States as a refugee under Section 207 of the Immigration and Naturalization Act (INA);

(ii) Has been granted asylum under Section 208 of the INA;

(iii) Is eligible for deportation, but the deportation is being withheld under Sections 241(b)(3) or 243(h) of the INA;

(iv) Is a lawfully admitted, permanent resident under the INA, and who has lived in the United States for five (5) or more consecutive years;

(v) Is lawfully residing within the State; and

(A) Is a veteran of the United States military service and received an honorable discharge (except such a discharge for alienage);

(B) On active duty with the United States military service, other than active duty for training; or

(C) Is the spouse or dependent child of a veteran or active member of the United States military.

(vi) Is a member of another group for which citizenship is met pursuant to the Balanced Budget Act of 1997, which is incorporated by this reference.

(cccc) "Residence" shall mean the place the insured uses as her primary dwelling place and intends to continue to use indefinitely for that purpose.

(dddd) "Resident" shall mean a person who lives in the State of Wyoming and has the intention of residing in the State.

(eeee) "Resource" shall mean real or personal property in which an individual has a legal or equitable interest.

(ffff) "Self declaration" shall mean the act of reporting information without supplying proof of the statements that you have made.

(gggg) "Services" shall mean health or medical services, medical supplies, or medical equipment.

(hhhh) "Shoe box method" shall mean the process of storing all of the receipts from co payments for medical, dental, and pharmacy covered services.

(iiii) "State fiscal year" shall mean July first (1^{st}) through June thirtieth (30^{th}) of the following calendar year.

(jjjj) "State funds" shall mean the state funds appropriated by the Wyoming Legislature for Kid Care CHIP. "State funds" may include grant funds received by the Department from a non-governmental source, if such funds are granted to constitute a portion of the State's expenditures for this program.

(kkkk) "System error" as defined in Chapter 39 of the Medicaid rules, which definition is incorporated by this reference.

(llll) "Termination" shall mean to remove an insured from the program or close the insured's file.

(mmmm) "Twelve (12) months of eligibility" shall mean the period of time in which a child is eligible for Kid Care CHIP, unless he moves out of state, enters an institution, turns nineteen (19), fails quality control, reaches her lifetime maximum, becomes eligible for Medicaid, and/or requests that the policy be closed.

(nnnn) "Well-baby or well-child services" shall mean the regular or preventive diagnostic and treatment services necessary to ensure the health of babies and children.

Section 5. Payments Only to Participating Insurance Companies.

(a) Payments for premiums shall be made only to participating insurance companies. No person or entity that furnishes a health insurance plan to an insured shall receive Kid Care CHIP funds unless the health insurance plan is offered by or through a participating insurance company.

(b) Submission of invoices. Any person or entity that submits an invoice for premiums, deductibles, or co-insurance, shall be deemed to have agreed to be bound by these Rules.

Section 6. Participating Insurance Company.

(a) No insurance company may participate in Kid Care CHIP, unless it offers a health insurance plan which meets or exceeds the basic level of benefits established pursuant to Chapter 3 and the insurance company has entered into a contract with the Department.

(b) Contracting process:

(i) The Department shall prepare and submit a Request for Proposal (RFP) to all private health insurance companies approved by the Wyoming Insurance Commissioner to do business in Wyoming. The RFP shall solicit bids to offer a health insurance plan which includes at least the basic level of benefits and a review process which allows an insured to seek review of the denial of non-covered services or any decision regarding coverage.

(ii) Compliance with RFP. An insurance company which wishes to participate in Kid Care CHIP must agree to meet and abide by all conditions as set forth in the RFP.

(iii) Premium level. The acceptable premium level for private health insurance plans shall be the most cost effective price submitted in response to the RFP.

(iv) New RFP. A reasonable time before the end of a period for which a contract has been entered, or at such time as the Department determines that it may be cost-effective to solicit new bids, the Department may issue a new RFP for the period after the expiration of the current contract.

Section 7. Insurance Contractor.

(a) The Department shall notify the participating insurance company of the identity of its participants and shall make premium payments on behalf of those participants directly to the company.

(b) The participating insurance company shall submit invoices to the Department in the manner specified by the Department to request reimbursement for premiums.

(c) When an insured seeks services, the provider must verify the individual's eligibility with the participating insurance company using the procedures established by

the company. If a provider fails to verify eligibility, the Department shall not be responsible for paying such services.

Section 8. Safeguarding Information. A participating insurance company must comply with the requirements of Chapter 38 of the Medicaid rules, which requirements are incorporated by this reference. All references in that Chapter to "Medicaid" shall be replaced with "Kid Care CHIP" for purposes of this Chapter.

Section 9. Payment and Submission of Invoices.

(a) Payment in full of covered services. If the service is a covered service, a participating insurance company may not request, receive, or attempt to collect any payment from the insured or the insured's family for the service, except for co-payments, pursuant to Chapter 4.

(b) Payment for non-covered services. A provider that provides a non-covered service to an insured may seek payment from the insured's parent or guardian, if the provider informed the parent or guardian, in writing, of the insured's potential liability before providing the service, and the parent or guardian agreed in writing to pay for such services before they were furnished.

(c) Submission of invoices.

(i) Invoices must be submitted to the Department in the manner and of the form specified by the Department;

(ii) The date of submission is the date the invoice is received by the Department.

Section 10. Recovery of Excess Payments. The Department may recover excess payments pursuant to Chapter 39 of the Medicaid rules. All references in that Chapter to "Medicaid" shall be replaced with "Kid Care CHIP" for purposes of this Chapter.

Section 11. Recovery of Overpayments. The Department may recover overpayments pursuant to Chapter 16 of the Medicaid rules. All references in that Chapter to "Medicaid" shall be replaced with "Kid Care CHIP" for purposes of this Chapter.

Section 12. Reconsideration and Contested Cases.

(a) A participating insurance company may request that the Department reconsider a decision to recover excess payments. Such request must be mailed to the Department by certified mail, return receipt requested, within twenty (20) days of the date the insurance company receives notice pursuant to Section 10. The reconsideration

provisions of Chapter 3 of the Medicaid rules, which provisions are incorporated by this reference, shall govern all aspects of the reconsideration and any administrative hearing.

(b) Eligibility determinations and redeterminations. An applicant or insured who is denied eligibility or terminated from eligibility may request a contested case pursuant to Chapter 1 of the Medicaid rules, which are incorporated by this reference. Chapter 1 of the Medicaid rules shall govern contested cases involving Kid Care CHIP eligibility issues in all respects, except that request for hearings on issues involving eligibility for Kid Care CHIP shall be mailed or hand-delivered to the Department within thirty (30) days from the date of the mailing of the notice of action.

(c) Denial of services or other coverage issues. An insured who is denied services or has any other complaint regarding whether services should be covered services shall be entitled to review of that decision pursuant to the procedures provided by the participating insurance company. Such action is not adverse action, and the insured shall not be entitled to reconsideration or an administrative appeal regarding such decision pursuant to this Section or Chapter 1.

Section 13. Disposition of Recovered Funds. Any and all recovered Kid Care CHIP funds shall be returned to the program and used to provide additional services.

Section 14. Contingent on Funding.

(a) Payment contingent on funding. In accordance with Program Expenditure provisions of the Act, payment to participating insurance companies is contingent on the availability of Kid Care CHIP funds. The Department shall not be obligated to make payments in the absence of such funds.

(b) Monitoring and projecting program expenditures. The Department shall:

(i) Monitor program expenditures to ensure that the expenditures do not exceed program funds;

(ii) Make monthly projections of expenditures for the remainder of the biennium based on program expenditures for the most recent six (6) calendar months, trended forward for the remainder of the biennium, and including utilization trends and the estimated amount of unpaid invoices.

(c) Program limitations. If the budget projections prepared pursuant to this Section show that there will or may be insufficient program funds, the Department may declare a partial or total moratorium on new insureds, so that otherwise eligible individuals will not be determined eligible until such time as the Department determines that sufficient program funds are available. Any such moratorium shall be no more restrictive than necessary to bring projected program expenditures into conformance with available program funds.

(d) Automatic termination of Kid Care CHIP. The program shall be automatically discontinued and reimbursement for premiums shall be suspended, when and if appropriated funds become exhausted.

(e) Notice of program reduction or termination. The Department shall provide thirty (30) days written notice, if possible, to participating insurance companies, providers, and insureds of any program reductions or termination of the program.

(f) No appeal. A program reduction or termination, or the denial of eligibility because of a moratorium, shall not be adverse actions, and shall not be subject to reconsideration pursuant to this Chapter or an administrative hearing pursuant to Chapter 1 of the Medicaid rules.

Section 15. Financial Audits. The Department may audit a participating insurance company's financial records at any time to determine the accuracy and appropriateness of invoices submitted to the Department. The Department may recover any excess payments pursuant to Section 10.

Section 16. 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 17. Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Department, including manuals or bulletins, which are inconsistent with this Chapter.

Section 18. Severability.

(a) If any portion of this Chapter is found to be invalid or unenforceable, the remainder shall continue in full force and effect.

(b) If any portion of this Chapter is inconsistent with the provisions required by HHS/The Centers for Medicare and Medicaid Services, as part of the State plan, the State Plan shall control.

CHAPTER 3

Rules and Regulations for Kid Care CHIP ("Children's Health Insurance Program")

Benefits

Section 1. Authority. This Chapter is promulgated by the Department of Health pursuant to the Child Health Insurance Program Act at W.S. §§ 35-25-101 through 35-25-111 and the Wyoming Administrative Procedure Act at W.S. § 16-3-101, *et seq.*

Section 2. Purpose and Applicability.

(a) This Chapter shall apply to and govern Kid Care CHIP. This Chapter shall become effective for Kid Care CHIP services provided on or after October 1, 2009.

(b) The Department may issue manuals, bulletins, or both, to interpret the provisions of this Chapter. Such manuals and bulletins shall be consistent with and reflect the policies contained in this Chapter. The provisions contained in manuals or bulletins shall be subordinate to the provisions of this Chapter.

Section 3. Health Benefits Plan Committee. A Health benefits plan committee was appointed pursuant to W.S. § 35-25-105, and submitted a list of recommended minimum services to the Department. That list comprises the basic level of benefits. Only those health insurance plans which provide the basic level of benefits as specified in this Chapter may be approved for participation in the program.

Section 4. Basic Level of Benefits. Health insurance plans must include coverage for at least the following services when medically necessary, subject to a one million dollar ($1,000,000.00) lifetime maximum benefit per child. Except as otherwise specified in this Section, coverage must be one hundred percent (100%), with no deductible or co-payments. Co-payments by insureds or their families shall be pursuant to Chapter 4.

(a) Abortion, if necessary to save the life of the mother or if the pregnancy is a result or an act of rape or incest.

(b) Comprehensive Outpatient Rehabilitation Facility (CORF) services, if prescribed or furnished by a physician or other practitioner.

(c) Inpatient mental health services, including:

(i) Services furnished in a State-operated mental hospital.

(ii) Services furnished in a residential or other twenty-four (24) hour

per day therapeutically planned structural setting.

(iii) ~~Inpatient hospital services (first level) are limited to twenty-one (21) days per benefit year. Partial hospitalization may be exchanged for inpatient hospital services at the rate of two (2) days of partial hospitalization to one (1) day of inpatient services. Partial hospitalization must meet the standards established by the American Association for Partial Hospitalization, which are incorporated by this reference.~~

~~(A) Inpatient hospital services (second level) provides for an additional nine (9) days of care, for a total of thirty (30) days per benefit year, with pre-approval and case management by the insurance company. The insurance company will work closely with the provider to ensure treatment plans are in place and managed.~~

~~(B) Limitations. A child who is a patient in an institute for mental disease (IMD) shall not be eligible for Kid Care CHIP, unless the child applied for the program before becoming a patient in the IMD.~~

~~(C) Unlimited services. No service limitations shall be imposed on children diagnosed with the following disorders, as defined by the American Psychiatric Association:~~

~~(I) Schizophrenia;~~

~~(II) Schizoaffective disorder;~~

~~(III) Bipolar disorder;~~

~~(IV) Major depression;~~

~~(V) Panic disorder;~~

~~(VI) Obsessive-compulsive disorder; or~~

~~(VII) Autism.~~

(iii) Inpatient substance abuse treatment services and residential substance abuse treatment service.

~~(A) Benefit year limitation. The combined benefit for inpatient and outpatient alcohol abuse treatment, substance abuse treatment, or both, other than costs for medical detoxification, is limited to six thousand dollars ($6,000.00) per benefit year, before a lifetime benefit of twelve thousand dollars ($12,000.00) is met. After that, the benefit year limitation is two thousand dollars ($2,000.00).~~

(A) Medical detoxification. Medical detoxification services shall be paid as any other inpatient hospital benefit.

(iv) Laboratory and radiological services for diagnostic or therapeutic purposes.

(v) Outpatient hospital services.

(vi) Outpatient mental health services ~~(first level)~~, including:

(A) Services furnished by a state-operated mental hospital; and

(B) Community-based services.

~~(C) Limitations.~~

~~(I) Twenty (20) visits per benefit year.~~

~~(II) Partial hospitalizations are covered as specified above.~~

~~(D) Outpatient mental health services (second level), provides for an additional twenty (20) outpatient visits per benefit year, for a total of forty (40) days per benefit year, with pre-approval and case management by the insurance company. The insurance company will work closely with the provider to ensure treatment plans are in place and managed. Providers will have the capability to bill for partial (thirty minutes or less) and full (more than thirty minutes) sessions. This capability only applies to the second level of benefits.~~

~~(E) Unlimited services. No service limitations shall be imposed on children diagnosed with the following disorders, as defined by the American Psychiatric Association:~~

~~(I) Schizophrenia;~~

~~(II) Schizoaffective disorder;~~

~~(III) Bipolar disorder;~~

~~(IV) Major depression;~~

~~(V) Panic disorder;~~

~~(VI) Obsessive compulsive disorder; or~~

~~(VIII) Autism~~

(vii) Outpatient substance abuse treatment services.

~~(A) Benefit year limitation. The combined benefit for inpatient and outpatient alcohol abuse treatment, substance abuse treatment, or both, other than costs for medical detoxification, is limited to six thousand dollars ($6,000.00) per benefit year, before a lifetime benefit of twelve thousand dollars ($12,000.00) is met. After than, the benefit year limitation is two thousand dollars ($2,000.00).~~

(A) Medical detoxification. Medical detoxification services shall be paid as any other inpatient hospital benefit.

(viii) Physician services provided by a physician, mid-level practitioner, or other covered provider, furnished in:

(A) The physician's office;

(B) A clinic;

(C) A patient's home;

(D) An outpatient surgery center; or

(E) A hospital.

(F) Routine physicals required for sports, employment, or government are covered.

(G) Anesthesia services are covered, if the surgical or hospital service which necessitates the anesthesia is covered.

(ix) Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders, up to seven hundred and fifty dollars ($750.00) per benefit year.

(x) Prenatal care and pre-pregnancy family services and supplies.

(xi) Prescription drugs; if prescribed by a practitioner acting within the scope of his or her practice, including;

(A) Chemotherapy drugs, if approved by the Food and Drug Administration.

(B) Vaccines;

(C) Prenatal vitamins; and

(D) Drugs necessitated by an organ or tissue transplant.

(E) Exclusions:

(I) Food supplements;

(II) Vitamins, other than prenatal; and

(III) Medical foods, other than those medically necessary to treat inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism, if a medically accepted method or diagnosis, treatment, and monitoring exists.

(xii) Spinal manipulation, up to two hundred fifty dollars ($250.00) per benefit year.

(xiii) Vision services.

(A) Services for the medical treatment of diseases or injury to the eye, if furnished by a physician or licensed optometrist.

(B) One vision exam per benefit year.

(C) One paid of lenses per benefit year, unless there is a change in the prescription.

(D) One pair of frames per benefit year up to one hundred dollars ($100.00) per benefit year. The family will be responsible for any amount in excess of one hundred dollars ($100.00).

(E) Contact lenses are covered up to one hundred dollars ($100.00) per benefit year. If the cost of the contacts is more than one hundred dollars ($100.00), families will be responsible for any additional cost.

(F) Either glasses or contacts for children, per benefit year, but not both. The program will not pay for both.

(xiv) Well-baby and well-child care up to the recommendations of the American Academy of Pediatrics. Immunizations are covered up to approved age tables.

(xv) Dental benefits. Exams, cleanings, bitewing x-rays, fluoride treatments, sealants, full mouth x-rays, space maintainers, fillings, simple extractions, emergency treatment for the relief of pain, pulpotomies and stainless steel crowns, gold

or porcelain crowns for teenagers with adult or permanent dentition, full-mouth debridement for teenagers with permanent dentition who have not seen a dentist in several years, partials for teenagers with permanent dentition missing anterior teeth, and sedation for younger children. Annual maximum is one thousand dollars ($1,000.00) per benefit year. Medically necessary dental services will be provided in addition to the one thousand dollar ($1,000.00) maximum and is only allowed if the service meets the definition of medical necessity determined by Kid Care CHIP and the Dental Contractor. Preventive and diagnostic services (exams, cleanings, fluoride, space maintainers, sealants, and x-rays) are subject only to frequency limitations, and are not included in the child's yearly benefit maximum. Medically necessary orthodontics will be covered only if the child meets the definition of orthodontic medical necessity determined by Kid Care CHIP and the Dental Contractor.

(xvi) Emergency medical transportation.

(xvii) Durable medical equipment.

(xviii) Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. Rehabilitative services are limited to twenty-five thousand dollars ($25,000.00) lifetime, if furnished by a physician or other practitioner acting within the scope of his or her license in a home, school, or other setting recognized by State law.

(xix) Inpatient hospital services.

(d) The RFP may require additional or different services, in which case the RFP shall control.

(e) Exclusions. In addition to the limitations specified above, the following services are not covered, unless the participating insurance company elects to cover them:

(i) Acupuncture;

(ii) Administrative transportation;

(iii) Biofeedback;

(iv) Chiropractic services;

(v) Cosmetic surgery;

(vi) Custodial care;

(vii) Contractual services;

(viii) Hearing aids;

(ix) Obesity treatment;

(x) General or Cosmetic orthodontic services;

(xi) Organ transplants;

(xii) Personal comfort, hygiene, or convenience items;

(xiii) Private duty nursing;

(xiv) Radial keratotomy;

(xv) Routine foot care;

(xvi) Tissue transplants;

(xvii) TMJ treatment; and

(xviii) Any services for which other coverage is available.

(f) The RFP may specify additional or different excluded services or limitations, in which case the RFP shall control.

(g) No exclusions for pre-existing conditions. No health insurance plan shall be approved if it excludes any pre-existing condition.

(h) Denial of non-covered services. The denial of services because they are not covered services is not an adverse action, and the insured shall not be entitled to reconsideration or administrative hearing pursuant to Chapter 1 of the Medicaid rules. The insured shall be entitled to, and shall be notified of that entitlement, of his or her right to seek review pursuant to the review procedures established by the participating insurance company.

CHAPTER 4

Rules and Regulations for Kid Care CHIP ("Children's Health Insurance Program")

Cost Sharing

Section 1. Authority. This Chapter is promulgated by the Department of Health pursuant to the Child Health Insurance Program Act at W.S. §§ 35-25-101 through 35-25-111 and the Wyoming Administrative Procedure Act at W.S. § 16-3-101, *et seq.*

Section 2. Purpose and Applicability.

(a) This Chapter shall apply to and govern Kid Care CHIP. This Chapter shall become effective for Kid Care CHIP services provided on or after October 1, 2009.

(b) The Department may issue manuals, bulletins, or both, to interpret the provisions of this Chapter. Such manuals and bulletins shall be consistent with and reflect the policies contained in this Chapter. The provisions contained in manuals or bulletins shall be subordinate to the provisions of this Chapter.

Section 3. Cost Sharing Maximums.

(a) Each family will be responsible for making co-payments pursuant to this subsection. Co-payments are capped at five percent (5%) of a family's gross annual income.

(b) Each family will be notified of their out of pocket maximum on their approval letter and their renewal approval letter.

(c) Families will track their out of pocket expenditures through a shoe box method and will be required to submit receipts each benefit year to the Department when they believe that they have met the annual out of pocket maximum.

(d) The Kid Care CHIP office along with the insurance contractor will tabulate the submitted receipts. Once the family has met the maximum, Kid Care CHIP will notify the insurance contractor and the family. Future Explanation of Benefits for that benefit year will indicate that the family has met the out of pocket maximum.

(e) If the family has paid more than their five percent (5%) out of pocket maximum, the family will be reimbursed by the insurance contractor.

Section 4. Co-payments.

(a) Plan A is for enrollees up to one hundred percent (100%) of the federal

poverty level and Native American or Alaskan Native children.

(i) There will be no co-payments for services.

(ii) There is no coverage for non-preferred brand drugs.

(b) Plan B is for enrollees from one hundred one percent (101%) through one hundred fifty percent (150%) of the federal poverty level.

(i) Maximum out of pocket per child for medical and vision is two hundred dollars ($200.00) per benefit year.

(A) Office visits (including mental health) = five dollars ($5.00)

(B) Outpatient hospital = five dollars ($5.00)

(C) Inpatient hospital = thirty dollars ($30.00)

(D) Emergency room = five dollars ($5.00)

(ii) Maximum out of pocket per child for pharmacy is one hundred dollars ($100.00) per benefit year.

(A) Generic prescriptions = three dollars ($3.00)

(B) Brand name prescriptions = five dollars ($5.00)

(C) There is no coverage for non-preferred brand drugs.

(iii) Maximum out of pocket per child for dental services is fifteen dollars ($15.00) per benefit year.

(A) Basic and major services = five dollars ($5.00)

(iv) Maximum out of pocket per child for medically necessary orthodontics is fifteen dollars ($15.00) per benefit year.

(c) Plan C is for enrollees from one hundred fifty one percent (151%) through two hundred percent (200%) of the federal poverty level.

(i) Maximum out of pocket per child for medical and vision is three hundred dollars ($300.00) per benefit year.

(A) Office visits (including mental health) = ten dollars

($10.00)

(B) Outpatient hospital = ten dollars ($10.00)

(C) Inpatient hospital = fifty dollars ($50.00)

(D) Emergency room = twenty-five dollars ($25.00)

(ii) Maximum out of pocket per child for pharmacy is two hundred dollars ($200.00) per benefit year.

(A) Generic prescriptions = five dollars ($5.00)

(B) Brand name prescriptions = ten dollars ($10.00)

(C) There is no coverage for non-preferred brand drugs.

(iii) Maximum out of pocket per child for dental services is seventy-five dollars ($75.00) per benefit year.

(A) Basic and major services = twenty-five dollars ($25.00)

(iv) Maximum out of pocket per child for medically necessary orthodontics is twenty five dollars ($25.00) per benefit year.

Section 5. Exclusions from Co-payments.

(a) No co-payment will be assessed for:

(i) Well-baby services;

(ii) Well-child services;

(iii) Preventive dental services; or

(iv) Services provided to American Indians or Alaska Natives.

(b) Failure to make co-payment. No insured shall be terminated because of the failure to make co-payments.

State of Wyoming
Department of Health

Chapters 1, 3 and 4
Rules and Regulations for Kid Care CHIP
("Children's Health Insurance Program")

Rules and Regulations for Kid Care CHIP
("Children's Health Insurance Program")
Wyoming Department of Health
Office of Healthcare Financing

Additional information and copies may be obtained from:
Patricia Guzman
Kid Care CHIP
6101 Yellowstone Rd., Ste. 210
Cheyenne, WY 82002
Phone: (307) 777-6228
Fax: (307) 777-7085
E-Mail: patricia.guzman@health.wyo.gov

This document is available in alternative format upon request.

CHAPTER 1
Rules for General Provisions

Section 1. Authority 1-1
Section 2. Purpose and Applicability 1-1
Section 3. General Provisions 1-1
Section 4. Definitions 1-1
Section 5. Payments Only to Participating Insurance Companies 1-11
Section 6. Participating Insurance Company 1-12
Section 7. Insurance Contractor 1-12
Section 8. Safeguarding Information 1-13
Section 9. Payment and Submission of Invoices 1-13
Section 10. Recovery of Excess Payments 1-13
Section 11. Recovery of Overpayments 1-13
Section 12. Reconsideration and Contested Cases 1-13
Section 13. Disposition of Recovered Funds 1-14
Section 14. Contingent on Funding 1-14
Section 15. Financial Audits 1-15
Section 16. Interpretation of Chapter 1-15
Section 17. Superseding Effect 1-15
Section 18. Severability 1-15

CHAPTER 3
Rules for Benefits

Section 1. Authority 3-1
Section 2. Purpose and Applicability 3-1
Section 3. Health Benefits Plan Committee 3-1
Section 4. Basic Level of Benefits 3-1

CHAPTER 4
Rules for Cost Sharing

Section 1. Authority 4-1
Section 2. Purpose and Applicability 4-1
Section 3. Cost Sharing Maximums 4-1
Section 4. Co-payments 4-1
Section 5. Exclusions from Co-payments 4-3

CHAPTER 1

Rules and Regulations for Kid Care CHIP ("Children's Health Insurance Program")

General Provisions

Section 1. Authority. This Chapter is promulgated by the Department of Health pursuant to the Child Health Insurance Program Act at W.S. §§ 35-25-101 through 35-25-111 and the Wyoming Administrative Procedure Act at W.S. § 16-3-101, *et seq.*

Section 2. Purpose and Applicability.

(a) This Chapter shall apply to and govern Kid Care CHIP. This Chapter shall become effective for Kid Care CHIP services provided on or after October 1, 2009.

(b) The Department may issue manuals, bulletins, or both to interpret the provision of this Chapter. Such manuals and bulletins shall be consistent with and reflect the policies contained in this Chapter. The provisions contained in manuals or bulletins shall be subordinate to the provisions of this Chapter.

Section 3. General Provisions.

(a) This Chapter is intended to be read in conjunction with the Child Health Insurance Program Act at W.S. §§ 35-25-101 through 35-25-111, Chapter 7 of Subchapter XXI of the Social Security Act codified at 42 U.S.C § 1397aa through 1397jj, and HHS Regulations at 42 C.F.R Part 457.

(b) In accordance with 42 U.S.C § 1397bb(b)(4), nothing in this Chapter shall be construed as providing an individual with an entitlement to Kid Care CHIP.

(c) The incorporation by reference of any external standard is intended to be the incorporation of that standard as it is in effect on the effective date of this Chapter.

Section 4. Definitions. The following definitions shall apply in the interpretation and enforcement of these rules. Where the context in which words are used in these rules indicates that such is the intent, words in the singular number shall include the plural and visa-versa. Throughout these rules gender pronouns are used interchangeably except where the context dictates otherwise. The drafters have attempted to utilize each gender pronoun in equal numbers in random distribution. Words in each gender shall include individuals of the other gender. Except as otherwise specified in this section, the terminology used in this Chapter is the standard terminology and has the standard meaning used in health care, health insurance, Medicare, and Medicaid.

For the purposes of these rules, the following shall apply:

(a) "Absent parent" shall mean any parent who is not providing care and control of the child or who cannot be counted on to function in the planning for the physical care, guidance, and maintenance of the child.

(b) "Act" shall mean the "Child Health Insurance Program Act," as enacted by the Wyoming Legislature and codified at W.S. §§ 35-25-101 through 35-25-111.

(c) "Adverse action" shall mean the denial, suspension, or termination of benefits, other than a suspension or termination caused by a suspension of Kid Care CHIP, pursuant to Section 14 or a change in Federal or State law, including an amendment to this Chapter. "Adverse action" does not include the denial of services because they are not covered services or other issues about the scope of covered services.

(d) "Alaska Native" shall mean an Eskimo, Aleut, or other Alaska Native enrolled by the United States Secretary of the Interior.

(e) "Alien" shall mean a person residing in Wyoming who is not a citizen of the United States of America.

(f) "American Indian" shall mean a person who is an enrolled member of a federally recognized Indian tribe, band, or group, or a first or second degree descendent of such person.

(g) "Applicant" shall mean a child on whose behalf an application for coverage by Kid Care CHIP has been submitted, but there has been no final determination of eligibility.

(h) "Application" shall mean the form, specified by the Department, on which an applicant indicates in writing the desire to receive benefits.

(i) "Application date" shall mean the date an application for Kid Care CHIP is received and date stamped by the Department.

(j) "Approve" shall mean to determine an applicant is eligible for Kid Care CHIP benefits.

(k) "Basis level of benefits" shall mean the level of benefits established by the Health Benefits Plan Committee pursuant to Chapter 3.

(l) "Benefits" shall mean the insurance coverage through Kid Care CHIP.

(m) "Benefit year" shall mean January to December of each year, so long as the insured remains eligible.

(n) "Biennium" shall mean the period covering two (2) State fiscal years following each regularly scheduled budget session of the Wyoming Legislature.

(o) "Caretaker" shall mean a person who is the physical custodian of a child.

(p) "Change in circumstances" shall mean a change in an insured's address or health insurance coverage.

(q) "Change report" shall mean a form, as prescribed by the Department, used to report a change in circumstances.

(r) "Chapter 1 of the Medicaid rules" shall mean Chapter 1, Medicaid Fair Hearings, of the Wyoming Medicaid rules.

(s) "Chapter 16 of the Medicaid rules" shall mean Chapter 16, Medicaid and State Funded Program Integrity, of the Wyoming Medicaid rules.

(t) "Chapter 38 of the Medicaid rules" shall mean Chapter 38, Safeguarding Information on Applicants and Recipients, of the Wyoming Medicaid rules.

(u) "Chapter 39 of the Medicaid rules" shall mean Chapter 39, Recovery of Excess Payments, of the Wyoming Medicaid rules.

(v) "Child" shall mean a person who is less than nineteen (19) years of age.

(w) "Citizen" shall mean an individual who is a citizen or the dependent of a citizen of the United States of America.

(x) "Centers for Medicare and Medicaid Services (CMS)" shall mean the federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program.

(y) "Contested case" as defined in Chapter 1 of the Medicaid rules, which definition is incorporated by this reference.

(z) "Cost sharing or co-payment" shall be a charge to an insured for receiving services covered under a health insurance plan.

(aa) "Countable income" shall mean income, including earned income, unearned income, and in-kind income, which is used to determined program eligibility. "Countable income" does not include exempt income.

(bb) "Cost-effective" shall mean the cost of providing program benefits does not exceed the average cost of similar programs in similar states, available state funds, or both.

(cc) "Covered services" shall mean those health services which are covered by a health insurance plan offered pursuant to Chapter 3. "Covered services" must include the basic level of benefits.

(dd) "Crowd out" shall mean the replacement or elimination of insurance by benefits offered pursuant to this Chapter.

(ee) "Department" shall mean the Wyoming Department of Health, its agent, designee, or successor.

(ff) "Dependent" shall mean one who relies on another for financial support.

(gg) "Dental medical necessity" shall mean that a covered service, in a manner consistent with accepted standards of medical practice, is:

(i) Consistent with the symptom, diagnosis and treatment of an insured's medical conditions;

(ii) Widely accepted by the practitioner's peer group as efficacious and reasonably safe based upon scientific evidence;

(iii) Not experimental, investigational, unproven, unusual or non-customary;

(iv) Not solely for cosmetic purposes;

(v) Not solely for the convenience of the insured, subscriber physician or other provider;

(vi) An appropriate level of care that can be safely provided to the insured, and failure to provide the covered service would adversely affect the insured's health;

(vii) When applied to inpatient care, further means that covered services cannot be safely provided in an ambulatory setting.

(hh) "Effective date of eligibility" shall mean a child found eligible for Kid Care CHIP whose application was received on or before the twenty-fifth (25^{th}) day of the month will be covered for services as of the first (1^{st}) day of the following month. If an application is received after the twenty-fifth (25^{th}) day of the month, the child will be covered for services as of the first (1^{st}) day of the month after the following month.

(ii) "Eligible" shall mean a person who is approved for Kid Care CHIP.

(jj) "Eligible child" shall mean a low income child who:

(i) Has not been covered by a health insurance plan for one (1) month or more before the date of application (unless the child loses health insurance through no fault of her own); or

(ii) Upon birth is not covered by a public or private health insurance plan; and who is not eligible for state employee dependent coverage; and

(iii) Is not in a public institution;

(iv) Is a U.S. resident or qualified alien;

(v) Is not eligible for Medicaid;

(vi) Has not yet reached his nineteenth (19^{th}) birthday;

(vii) Has not reached his lifetime maximum.

(kk) "Excess payments" shall mean Kid Care CHIP funds received by a participating insurance company to which the company is not entitled for any reason. "Excess payments" includes, but is not limited to:

(i) Overpayments;

(ii) Payments made as a result of system errors;

(iii) Payments for premiums or services furnished to a non-insured;

(iv) Payments for non-covered services furnished to an insured; or

(v) Payments which exceed the contract rate agreed to by the participating insurance company.

(ll) "Explanation of benefits form (EOB)" shall mean a form sent by the insurance contractor to both providers of a service and the enrolled child. EOBs provide information, claim payment, and client responsibility.

(mm) "Family" shall mean one or more children residing in the same household with one or both natural parents, adoptive parents, a guardian, or a caretaker.

(nn) "Federal funds" shall mean the Federal funds received by the Department pursuant to 42 U.S.C.A. § 1397ee to pay for Kid Care CHIP costs.

(oo) "Federal poverty level (FPL)" shall mean the poverty guideline updated annually in the Federal Register by HHS under the authority of Section 673(2) of the Omnibus Reconciliation Act of 1981.

(pp) "Financially responsible adult" shall mean the person or persons legally responsible to support one or more low income children. "Financially responsible adult" may include a caretaker.

(qq) "Financial records" shall mean all records, in whatever form, used or maintained by a participating insurance company in the conduct of its business affairs and which are necessary to substantiate or understand invoices submitted to the Department.

(rr) "Guardian" shall mean a child's legally appointed conservator or guardian.

(ss) "Health benefits plan committee" shall mean the committee appointed pursuant to W.S. §§ 35-25-105 to establish the basic level of benefits.

(tt) "Health insurance plan" shall mean an individual insurance policy or contract for the purpose of paying for or reimbursing the cost of hospital and medical care. "Health insurance plan" includes private insurance plans.

(uu) "HHS" shall mean the United States Department of Health and Human Services, its agent, designee, or successor.

(vv) "Household" shall mean the person or persons who live together in a residence. A "household" may include one or more families.

(ww) "Illegal alien" shall mean a foreign national who:

(i) Entered the U.S. without inspection or with fraudulent documentation; or

(ii) After entering legally as a nonimmigrant, violated status and remained in the U.S. without permission.

(xx) "Income" shall mean gross earned income, unearned income, or in-kind payments received from any source, excluding money classified as a resource or exempt income:

(i) Earned income includes:

(A) Any payment received by an employee or agent in cash or in-kind as wages, salary, tips, commissions, or pursuant to a contract.

(B) Net profits received from activities in which the individual is engaged (self-employment). "Net profits" means the total sum after deductions for personal or employment expenses and excludes the meal allowance used by the Federal

Insurance Contribution Act (FICA). A family may deduct twenty-five percent (25%) of its gross self-employment income or it may deduct actual business expenses; however, depreciation may not be deducted.

(ii) Exempt income is money set aside or free from program policy limits and not counted against program income limits. The following income is exempt:

(A) Income which is required to be excluded under a federal statute;

(B) Unearned income paid in-kind to a household member, such as payment made to a third party for food, shelter, clothing, or other needs;

(C) Educational income, such as grants, scholarships, fellowships, education loans, and work-study income paid to a person who is enrolled in an educational program. Educational income received in excess of education expenses is not exempt;

(D) Needs-based veterans' benefits;

(E) Reimbursement for expenses incurred by the individual; and

(F) Child care assistance paid under Title XX of the Social Security Act.

(yy) "Ineligible" shall mean not authorized to be an insured under Kid Care CHIP.

(zz) "Inmate of a public institution" as defined in 42 C.F.R. § 435.1009, which definition is incorporated by this reference.

(aaa) "Institute for mental disease" as defined in 42 C.F.R. § 435.1009, which definition is incorporated by this reference.

(bbb) "Insured" shall mean a low income child who has been determined eligible for Kid Care CHIP.

(ccc) "Invoice" shall mean a request by a participating insurance company for payment of Kid Care CHIP funds for insurance premiums.

(ddd) "Kid Care CHIP" shall mean the Children's Health Insurance Program established pursuant to the Child Health Insurance Program Act, W.S. §§ 32-25-101 through 35-25-111.

(eee) "Kid Care CHIP funds" shall mean that combination of Federal funds and State funds which is available to the Department to make payments to participating insurance companies for insurance coverage furnished to eligible children.

(fff) "Kid Care CHIP state plan" shall mean the state plan prepared by the Department pursuant to 42 U.S.C. § 1397aa(b) and submitted to HHS.

(ggg) "Low-income child" shall mean a child whose family's gross monthly income as determined pursuant to Chapter 2 is not more than two hundred percent (200%) of the federal poverty level.

(hhh) "Medicaid" shall mean medical assistance and services provided pursuant to Title XIX of the Social Security Act or the Wyoming Medical Assistance and Services Act of 1967, as amended. "Medicaid" includes any successor or replacement program enacted by Congress or the Wyoming Legislature. "Medicaid" in Wyoming is also called "EqualityCare."

(iii) "Medically necessary" or "medical necessity" shall mean a health service that is required to diagnose, treat, cure, or prevent an illness, injury, or disease which has been diagnosed or is reasonably suspected; to relieve pain; or to improve and preserve health and be essential to life. The service must be:

(i) Consistent with the diagnoses and treatment of the insured's condition;

(ii) In accordance with the standards of good medical practice among the provider's peer group;

(iii) Required to meet the medical needs of the insured and undertaken for reasons other than the convenience of the insured and the provider; and

(iv) Performed in the most cost effective and appropriate setting required by the insured's condition.

(jjj) "Medical records" shall mean all records, in whatever form, in the possession of or subject to the control of a participating insurance company which describes the insured's diagnosis, treatment, or condition.

(kkk) "Mid-level practitioner" shall mean a physician's assistant, a certified nurse practitioner, a certified nurse midwife, or any other licensed health care professional authorized to diagnose and treat patients.

(lll) "Month" shall mean a calendar month.

(mmm)"Notice of action" shall mean a written notice mailed to an insured which informs the insured of intended action affecting eligibility for benefits. The notice shall include the action to be taken, the effective date of the action, and the legal authority for the action. Notice shall be timely if mailed, by first-class United States mail, ten (10) days before the effective date of the intended action.

(nnn) "Orthodontia medical necessity" shall mean medically necessary orthodontic services or cranial facial orthopedic deformities with an evaluation report from an orthodontist. This benefit is not available for patients currently under treatment in another State run program or through a private pay arrangement. Orthodontia medical necessity shall be determined by the dental contractor's orthodontic consultant.

(ooo) "Out of pocket maximum" shall mean the most money in cost sharing that a household will have to pay in a given benefit year. This amount is capped at five percent (5%) of the household's gross annual income. Once the out of pocket maximum has been met, the family will not pay any more cost sharing until the next benefit year begins.

(ppp) "Overpayments" shall mean Kid Care CHIP funds received by a participating insurance company as the result of fraud or abuse, as those terms are defined in Chapter 16 of the Medicaid rules, which definitions are incorporated by this reference.

(qqq) "Participating insurance company" shall mean an insurance company which has contracted with the Department to provide benefits to eligible children.

(rrr) "Periodic review" shall mean a review of an insured's eligibility. A "periodic review" shall be conducted every twelve (12) months after the effective date of eligibility.

(sss) "Plan A" shall mean the Kid Care CHIP plan that includes Native American children, Alaskan Native children, and those children whose family income is one hundred percent (100%) or lower of the federal poverty level.

(ttt) "Plan B" shall mean the Kid Care CHIP plan that includes children from one hundred one percent (101%) to one hundred fifty percent (150%) of the federal poverty level.

(uuu) "Plan C" shall mean the Kid Care CHIP plan that includes children from one hundred fifty one percent (151%) to two hundred percent (200%) of the federal poverty level.

(vvv) "Practitioner" shall mean a physician, nurse practitioner, dentist, optometrist, or any other health care professional acting within the scope of her practice.

(www) "Pre-existing condition" shall mean an illness, injury, or health condition which exists as of the application date.

(xxx) "Premium" shall mean the payment necessary to pay for a health insurance plan provided to an eligible child.

(yyy) "Private insurance plan" shall mean a health insurance plan which is not an employer-based plan.

(zzz) "Program" shall mean Kid Care CHIP.

(aaaa) "Provider" shall mean an individual or entity that has an agreement with a participating insurance company to furnish services to an insured.

(bbbb) "Qualified alien" shall mean a lawfully admitted alien who qualifies if he:

(i) Is admitted to the United States as a refugee under Section 207 of the Immigration and Naturalization Act (INA);

(ii) Has been granted asylum under Section 208 of the INA;

(iii) Is eligible for deportation, but the deportation is being withheld under Sections 241(b)(3) or 243(h) of the INA;

(iv) Is a lawfully admitted, permanent resident under the INA, and who has lived in the United States for five (5) or more consecutive years;

(v) Is lawfully residing within the State; and

(A) Is a veteran of the United States military service and received an honorable discharge (except such a discharge for alienage);

(B) On active duty with the United States military service, other than active duty for training; or

(C) Is the spouse or dependent child of a veteran or active member of the United States military.

(vi) Is a member of another group for which citizenship is met pursuant to the Balanced Budget Act of 1997, which is incorporated by this reference.

(cccc) "Residence" shall mean the place the insured uses as her primary dwelling place and intends to continue to use indefinitely for that purpose.

(dddd) "Resident" shall mean a person who lives in the State of Wyoming and has the intention of residing in the State.

(eeee) "Resource" shall mean real or personal property in which an individual has a legal or equitable interest.

(ffff) "Self declaration" shall mean the act of reporting information without supplying proof of the statements that you have made.

(gggg) "Services" shall mean health or medical services, medical supplies, or medical equipment.

(hhhh) "Shoe box method" shall mean the process of storing all of the receipts from co payments for medical, dental, and pharmacy covered services.

(iiii) "State fiscal year" shall mean July first (1^{st}) through June thirtieth (30^{th}) of the following calendar year.

(jjjj) "State funds" shall mean the state funds appropriated by the Wyoming Legislature for Kid Care CHIP. "State funds" may include grant funds received by the Department from a non-governmental source, if such funds are granted to constitute a portion of the State's expenditures for this program.

(kkkk) "System error" as defined in Chapter 39 of the Medicaid rules, which definition is incorporated by this reference.

(llll) "Termination" shall mean to remove an insured from the program or close the insured's file.

(mmmm) "Twelve (12) months of eligibility" shall mean the period of time in which a child is eligible for Kid Care CHIP, unless he moves out of state, enters an institution, turns nineteen (19), fails quality control, reaches her lifetime maximum, becomes eligible for Medicaid, and/or requests that the policy be closed.

(nnnn) "Well-baby or well-child services" shall mean the regular or preventive diagnostic and treatment services necessary to ensure the health of babies and children.

Section 5. Payments Only to Participating Insurance Companies.

(a) Payments for premiums shall be made only to participating insurance companies. No person or entity that furnishes a health insurance plan to an insured shall receive Kid Care CHIP funds unless the health insurance plan is offered by or through a participating insurance company.

(b) Submission of invoices. Any person or entity that submits an invoice for premiums, deductibles, or co-insurance, shall be deemed to have agreed to be bound by these Rules.

Section 6. Participating Insurance Company.

(a) No insurance company may participate in Kid Care CHIP, unless it offers a health insurance plan which meets or exceeds the basic level of benefits established pursuant to Chapter 3 and the insurance company has entered into a contract with the Department.

(b) Contracting process:

(i) The Department shall prepare and submit a Request for Proposal (RFP) to all private health insurance companies approved by the Wyoming Insurance Commissioner to do business in Wyoming. The RFP shall solicit bids to offer a health insurance plan which includes at least the basic level of benefits and a review process which allows an insured to seek review of the denial of non-covered services or any decision regarding coverage.

(ii) Compliance with RFP. An insurance company which wishes to participate in Kid Care CHIP must agree to meet and abide by all conditions as set forth in the RFP.

(iii) Premium level. The acceptable premium level for private health insurance plans shall be the most cost effective price submitted in response to the RFP.

(iv) New RFP. A reasonable time before the end of a period for which a contract has been entered, or at such time as the Department determines that it may be cost-effective to solicit new bids, the Department may issue a new RFP for the period after the expiration of the current contract.

Section 7. Insurance Contractor.

(a) The Department shall notify the participating insurance company of the identity of its participants and shall make premium payments on behalf of those participants directly to the company.

(b) The participating insurance company shall submit invoices to the Department in the manner specified by the Department to request reimbursement for premiums.

(c) When an insured seeks services, the provider must verify the individual's eligibility with the participating insurance company using the procedures established by

the company. If a provider fails to verify eligibility, the Department shall not be responsible for paying such services.

Section 8. Safeguarding Information. A participating insurance company must comply with the requirements of Chapter 38 of the Medicaid rules, which requirements are incorporated by this reference. All references in that Chapter to "Medicaid" shall be replaced with "Kid Care CHIP" for purposes of this Chapter.

Section 9. Payment and Submission of Invoices.

(a) Payment in full of covered services. If the service is a covered service, a participating insurance company may not request, receive, or attempt to collect any payment from the insured or the insured's family for the service, except for co-payments, pursuant to Chapter 4.

(b) Payment for non-covered services. A provider that provides a non-covered service to an insured may seek payment from the insured's parent or guardian, if the provider informed the parent or guardian, in writing, of the insured's potential liability before providing the service, and the parent or guardian agreed in writing to pay for such services before they were furnished.

(c) Submission of invoices.

(i) Invoices must be submitted to the Department in the manner and of the form specified by the Department;

(ii) The date of submission is the date the invoice is received by the Department.

Section 10. Recovery of Excess Payments. The Department may recover excess payments pursuant to Chapter 39 of the Medicaid rules. All references in that Chapter to "Medicaid" shall be replaced with "Kid Care CHIP" for purposes of this Chapter.

Section 11. Recovery of Overpayments. The Department may recover overpayments pursuant to Chapter 16 of the Medicaid rules. All references in that Chapter to "Medicaid" shall be replaced with "Kid Care CHIP" for purposes of this Chapter.

Section 12. Reconsideration and Contested Cases.

(a) A participating insurance company may request that the Department reconsider a decision to recover excess payments. Such request must be mailed to the Department by certified mail, return receipt requested, within twenty (20) days of the date the insurance company receives notice pursuant to Section 10. The reconsideration

provisions of Chapter 3 of the Medicaid rules, which provisions are incorporated by this reference, shall govern all aspects of the reconsideration and any administrative hearing.

(b) Eligibility determinations and redeterminations. An applicant or insured who is denied eligibility or terminated from eligibility may request a contested case pursuant to Chapter 1 of the Medicaid rules, which are incorporated by this reference. Chapter 1 of the Medicaid rules shall govern contested cases involving Kid Care CHIP eligibility issues in all respects, except that request for hearings on issues involving eligibility for Kid Care CHIP shall be mailed or hand-delivered to the Department within thirty (30) days from the date of the mailing of the notice of action.

(c) Denial of services or other coverage issues. An insured who is denied services or has any other complaint regarding whether services should be covered services shall be entitled to review of that decision pursuant to the procedures provided by the participating insurance company. Such action is not adverse action, and the insured shall not be entitled to reconsideration or an administrative appeal regarding such decision pursuant to this Section or Chapter 1.

Section 13. Disposition of Recovered Funds. Any and all recovered Kid Care CHIP funds shall be returned to the program and used to provide additional services.

Section 14. Contingent on Funding.

(a) Payment contingent on funding. In accordance with Program Expenditure provisions of the Act, payment to participating insurance companies is contingent on the availability of Kid Care CHIP funds. The Department shall not be obligated to make payments in the absence of such funds.

(b) Monitoring and projecting program expenditures. The Department shall:

(i) Monitor program expenditures to ensure that the expenditures do not exceed program funds;

(ii) Make monthly projections of expenditures for the remainder of the biennium based on program expenditures for the most recent six (6) calendar months, trended forward for the remainder of the biennium, and including utilization trends and the estimated amount of unpaid invoices.

(c) Program limitations. If the budget projections prepared pursuant to this Section show that there will or may be insufficient program funds, the Department may declare a partial or total moratorium on new insureds, so that otherwise eligible individuals will not be determined eligible until such time as the Department determines that sufficient program funds are available. Any such moratorium shall be no more restrictive than necessary to bring projected program expenditures into conformance with available program funds.

(d) Automatic termination of Kid Care CHIP. The program shall be automatically discontinued and reimbursement for premiums shall be suspended, when and if appropriated funds become exhausted.

(e) Notice of program reduction or termination. The Department shall provide thirty (30) days written notice, if possible, to participating insurance companies, providers, and insureds of any program reductions or termination of the program.

(f) No appeal. A program reduction or termination, or the denial of eligibility because of a moratorium, shall not be adverse actions, and shall not be subject to reconsideration pursuant to this Chapter or an administrative hearing pursuant to Chapter 1 of the Medicaid rules.

Section 15. Financial Audits. The Department may audit a participating insurance company's financial records at any time to determine the accuracy and appropriateness of invoices submitted to the Department. The Department may recover any excess payments pursuant to Section 10.

Section 16. 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 17. Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Department, including manuals or bulletins, which are inconsistent with this Chapter.

Section 18. Severability.

(a) If any portion of this Chapter is found to be invalid or unenforceable, the remainder shall continue in full force and effect.

(b) If any portion of this Chapter is inconsistent with the provisions required by HHS/The Centers for Medicare and Medicaid Services, as part of the State plan, the State Plan shall control.

CHAPTER 3

Rules and Regulations for Kid Care CHIP ("Children's Health Insurance Program")

Benefits

Section 1. Authority. This Chapter is promulgated by the Department of Health pursuant to the Child Health Insurance Program Act at W.S. §§ 35-25-101 through 35-25-111 and the Wyoming Administrative Procedure Act at W.S. § 16-3-101, *et seq.*

Section 2. Purpose and Applicability.

(a) This Chapter shall apply to and govern Kid Care CHIP. This Chapter shall become effective for Kid Care CHIP services provided on or after October 1, 2009.

(b) The Department may issue manuals, bulletins, or both, to interpret the provisions of this Chapter. Such manuals and bulletins shall be consistent with and reflect the policies contained in this Chapter. The provisions contained in manuals or bulletins shall be subordinate to the provisions of this Chapter.

Section 3. Health Benefits Plan Committee. A Health benefits plan committee was appointed pursuant to W.S. § 35-25-105, and submitted a list of recommended minimum services to the Department. That list comprises the basic level of benefits. Only those health insurance plans which provide the basic level of benefits as specified in this Chapter may be approved for participation in the program.

Section 4. Basic Level of Benefits. Health insurance plans must include coverage for at least the following services when medically necessary, subject to a one million dollar ($1,000,000.00) lifetime maximum benefit per child. Except as otherwise specified in this Section, coverage must be one hundred percent (100%), with no deductible or co-payments. Co-payments by insureds or their families shall be pursuant to Chapter 4.

(a) Abortion, if necessary to save the life of the mother or if the pregnancy is a result or an act of rape or incest.

(b) Comprehensive Outpatient Rehabilitation Facility (CORF) services, if prescribed or furnished by a physician or other practitioner.

(c) Inpatient mental health services, including:

(i) Services furnished in a State-operated mental hospital.

(ii) Services furnished in a residential or other twenty-four (24) hour

per day therapeutically planned structural setting.

(iii) Inpatient substance abuse treatment services and residential substance abuse treatment service.

(A) Medical detoxification. Medical detoxification services shall be paid as any other inpatient hospital benefit.

(iv) Laboratory and radiological services for diagnostic or therapeutic purposes.

(v) Outpatient hospital services.

(vi) Outpatient mental health services, including:

(A) Services furnished by a state-operated mental hospital; and

(B) Community-based services.

(vii) Outpatient substance abuse treatment services.

(A) Medical detoxification. Medical detoxification services shall be paid as any other inpatient hospital benefit.

(viii) Physician services provided by a physician, mid-level practitioner, or other covered provider, furnished in:

(A) The physician's office;

(B) A clinic;

(C) A patient's home;

(D) An outpatient surgery center; or

(E) A hospital.

(F) Routine physicals required for sports, employment, or government are covered.

(G) Anesthesia services are covered, if the surgical or hospital service which necessitates the anesthesia is covered.

(ix) Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders, up to seven hundred and fifty

dollars ($750.00) per benefit year.

(x) Prenatal care and pre-pregnancy family services and supplies.

(xi) Prescription drugs; if prescribed by a practitioner acting within the scope of his or her practice, including;

(A) Chemotherapy drugs, if approved by the Food and Drug Administration.

(B) Vaccines;

(C) Prenatal vitamins; and

(D) Drugs necessitated by an organ or tissue transplant.

(E) Exclusions:

(I) Food supplements;

(II) Vitamins, other than prenatal; and

(III) Medical foods, other than those medically necessary to treat inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism, if a medically accepted method or diagnosis, treatment, and monitoring exists.

(xii) Spinal manipulation, up to two hundred fifty dollars ($250.00) per benefit year.

(xiii) Vision services.

(A) Services for the medical treatment of diseases or injury to the eye, if furnished by a physician or licensed optometrist.

(B) One vision exam per benefit year.

(C) One paid of lenses per benefit year, unless there is a change in the prescription.

(D) One pair of frames per benefit year up to one hundred dollars ($100.00) per benefit year. The family will be responsible for any amount in excess of one hundred dollars ($100.00).

(E) Contact lenses are covered up to one hundred dollars ($100.00) per benefit year. If the cost of the contacts is more than one hundred dollars

($100.00), families will be responsible for any additional cost.

(F) Either glasses or contacts for children, per benefit year, but not both. The program will not pay for both.

(xiv) Well-baby and well-child care up to the recommendations of the American Academy of Pediatrics. Immunizations are covered up to approved age tables.

(xv) Dental benefits. Exams, cleanings, bitewing x-rays, fluoride treatments, sealants, full mouth x-rays, space maintainers, fillings, simple extractions, emergency treatment for the relief of pain, pulpotomies and stainless steel crowns, gold or porcelain crowns for teenagers with adult or permanent dentition, full-mouth debridement for teenagers with permanent dentition who have not seen a dentist in several years, partials for teenagers with permanent dentition missing anterior teeth, and sedation for younger children. Annual maximum is one thousand dollars ($1,000.00) per benefit year. Medically necessary dental services will be provided in addition to the one thousand dollar ($1,000.00) maximum and is only allowed if the service meets the definition of medical necessity determined by Kid Care CHIP and the Dental Contractor. Preventive and diagnostic services (exams, cleanings, fluoride, space maintainers, sealants, and x-rays) are subject only to frequency limitations, and are not included in the child's yearly benefit maximum. Medically necessary orthodontics will be covered only if the child meets the definition of orthodontic medical necessity determined by Kid Care CHIP and the Dental Contractor.

(xvi) Emergency medical transportation.

(xvii) Durable medical equipment.

(xviii) Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. Rehabilitative services are limited to twenty-five thousand dollars ($25,000.00) lifetime, if furnished by a physician or other practitioner acting within the scope of his or her license in a home, school, or other setting recognized by State law.

(xix) Inpatient hospital services.

(d) The RFP may require additional or different services, in which case the RFP shall control.

(e) Exclusions. In addition to the limitations specified above, the following services are not covered, unless the participating insurance company elects to cover them:

(i) Acupuncture;

(ii) Administrative transportation;

(iii) Biofeedback;

(iv) Chiropractic services;

(v) Cosmetic surgery;

(vi) Custodial care;

(vii) Contractual services;

(viii) Hearing aids;

(ix) Obesity treatment;

(x) General or Cosmetic orthodontic services;

(xi) Organ transplants;

(xii) Personal comfort, hygiene, or convenience items;

(xiii) Private duty nursing;

(xiv) Radial keratotomy;

(xv) Routine foot care;

(xvi) Tissue transplants;

(xvii) TMJ treatment; and

(xviii) Any services for which other coverage is available.

(f) The RFP may specify additional or different excluded services or limitations, in which case the RFP shall control.

(g) No exclusions for pre-existing conditions. No health insurance plan shall be approved if it excludes any pre-existing condition.

(h) Denial of non-covered services. The denial of services because they are not covered services is not an adverse action, and the insured shall not be entitled to reconsideration or administrative hearing pursuant to Chapter 1 of the Medicaid rules. The insured shall be entitled to, and shall be notified of that entitlement, of his or her right to seek review pursuant to the review procedures established by the participating insurance company.

CHAPTER 4

Rules and Regulations for Kid Care CHIP ("Children's Health Insurance Program")

Cost Sharing

Section 1. Authority. This Chapter is promulgated by the Department of Health pursuant to the Child Health Insurance Program Act at W.S. §§ 35-25-101 through 35-25-111 and the Wyoming Administrative Procedure Act at W.S. § 16-3-101, *et seq.*

Section 2. Purpose and Applicability.

(a) This Chapter shall apply to and govern Kid Care CHIP. This Chapter shall become effective for Kid Care CHIP services provided on or after October 1, 2009.

(b) The Department may issue manuals, bulletins, or both, to interpret the provisions of this Chapter. Such manuals and bulletins shall be consistent with and reflect the policies contained in this Chapter. The provisions contained in manuals or bulletins shall be subordinate to the provisions of this Chapter.

Section 3. Cost Sharing Maximums.

(a) Each family will be responsible for making co-payments pursuant to this subsection. Co-payments are capped at five percent (5%) of a family's gross annual income.

(b) Each family will be notified of their out of pocket maximum on their approval letter and their renewal approval letter.

(c) Families will track their out of pocket expenditures through a shoe box method and will be required to submit receipts each benefit year to the Department when they believe that they have met the annual out of pocket maximum.

(d) The Kid Care CHIP office along with the insurance contractor will tabulate the submitted receipts. Once the family has met the maximum, Kid Care CHIP will notify the insurance contractor and the family. Future Explanation of Benefits for that benefit year will indicate that the family has met the out of pocket maximum.

(e) If the family has paid more than their five percent (5%) out of pocket maximum, the family will be reimbursed by the insurance contractor.

Section 4. Co-payments.

(a) Plan A is for enrollees up to one hundred percent (100%) of the federal

poverty level and Native American or Alaskan Native children.

(i) There will be no co-payments for services.

(ii) There is no coverage for non-preferred brand drugs.

(b) Plan B is for enrollees from one hundred one percent (101%) through one hundred fifty percent (150%) of the federal poverty level.

(i) Maximum out of pocket per child for medical and vision is two hundred dollars ($200.00) per benefit year.

(A) Office visits (including mental health) = five dollars ($5.00)

(B) Outpatient hospital = five dollars ($5.00)

(C) Inpatient hospital = thirty dollars ($30.00)

(D) Emergency room = five dollars ($5.00)

(ii) Maximum out of pocket per child for pharmacy is one hundred dollars ($100.00) per benefit year.

(A) Generic prescriptions = three dollars ($3.00)

(B) Brand name prescriptions = five dollars ($5.00)

(C) There is no coverage for non-preferred brand drugs.

(iii) Maximum out of pocket per child for dental services is fifteen dollars ($15.00) per benefit year.

(A) Basic and major services = five dollars ($5.00)

(iv) Maximum out of pocket per child for medically necessary orthodontics is fifteen dollars ($15.00) per benefit year.

(c) Plan C is for enrollees from one hundred fifty one percent (151%) through two hundred percent (200%) of the federal poverty level.

(i) Maximum out of pocket per child for medical and vision is three hundred dollars ($300.00) per benefit year.

(A) Office visits (including mental health) = ten dollars

($10.00)

(B) Outpatient hospital = ten dollars ($10.00)

(C) Inpatient hospital = fifty dollars ($50.00)

(D) Emergency room = twenty-five dollars ($25.00)

(ii) Maximum out of pocket per child for pharmacy is two hundred dollars ($200.00) per benefit year.

(A) Generic prescriptions = five dollars ($5.00)

(B) Brand name prescriptions = ten dollars ($10.00)

(C) There is no coverage for non-preferred brand drugs.

(iii) Maximum out of pocket per child for dental services is seventy-five dollars ($75.00) per benefit year.

(A) Basic and major services = twenty-five dollars ($25.00)

(iv) Maximum out of pocket per child for medically necessary orthodontics is twenty five dollars ($25.00) per benefit year.

Section 5. Exclusions from Co-payments.

(a) No co-payment will be assessed for:

(i) Well-baby services;

(ii) Well-child services;

(iii) Preventive dental services; or

(iv) Services provided to American Indians or Alaska Natives.

(b) Failure to make co-payment. No insured shall be terminated because of the failure to make co-payments.