State of Wyoming

Department of Health
Public Health Division
Rural and Frontier Health Section
Office of Rural Health

Rules and Regulations for the
Wyoming Primary Care Support Grant Program

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State of Wyoming
Department of Health

Chapter 8
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Chapter 8. The Wyoming Primary Care Support Grant Program

Intent to Adopt

Statement of Reasons

The Wyoming Department of Health proposes the following Rule to comply with the provisions of the Wyoming Primary Care Support Act which was established in the 2011 General Session at House Enrolled Act (HEA) 65. This Act is codified at W.S. § 9-2-127. This Act, HEA 65, and the Wyoming Administrative Procedures Act at W.S. § 16-3-101, *et seq.,* authorize the Department of Health to promulgate a Rule to implement the Wyoming Primary Care Support Grant Program.

This Proposed Rule establishes the Wyoming Primary Care Support Grant Program.

As required by W.S. § 16-3-103(a)(i)(G), the Rule implementing the Wyoming Primary Care Support Grant Program meets minimum substantive state statutory requirements.

THE WYOMING PRIMARY CARE SUPPORT GRANT PROGRAM

CHAPTER 8

Section 1.	Authority……..	8-1
Section 2.	Purpose and Applicability……	8-1
Section 3.	Severability……...	8-1
Section 4.	Definitions……	8-1
Section 5.	Primary Care Support Grants – Terms and Service…….	8-4
Section 6.	Department Responsibilities……	8-4
Section 7.	Applicant/Grantee Responsibilities……..	8-6
Section 8.	Eligibility Criteria for Primary Care Support Grant Applicants…..	8-7
Section 9.	Application Process……..	8-8
Section 10.	Selection Process……..	8-10
Section 11.	Primary Care Support Grant Program Breach, Repayment and Penalties……...	8-11
Section 12.	Reporting Requirements……...	8-12

THE WYOMING PRIMARY CARE SUPPORT GRANT PROGRAM

CHAPTER 8

Section 1. Authority.

These Rules are promulgated by the Department of Health, Public Health Division, Rural and Frontier Health Section, Office of Rural Health, pursuant to W.S. § 9-2-127, and the Wyoming Administrative Procedures Act at W.S. 16-3-101, *et seq*.

Section 2. Purpose and Applicability.

(a) These Rules implement the Wyoming Primary Care Support Grant Program and create a process for facilitating the award of grant funds to Community Health Centers and Rural Health Clinics for capital construction and start-up costs, as follows:

(i) As one-time start-up costs of a new Community Health Center or Rural Health Clinic; or

(ii) To allow existing Community Health Centers or Rural Health Clinics to expand the population served; or

(iii) To allow existing Community Health Centers or Rural Health Clinics to initiate new services; or

(iv) To allow existing Community Health Centers or Rural Health Clinics to facilitate compliance with quality criteria.

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

(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 these Rules and regulations.

Section 3. Severability.

If any portion of these Rules is found to be invalid or unenforceable, the remainder shall continue in effect.

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.

For the purpose of these Rules, the following shall apply:

(a) "Access to care programs" means Wyoming funded programs designed to increase the number of healthcare professionals working in areas of greatest need for primary care access in Wyoming as determined by the Department.

(b) "Applicant" means an existing or new Community Health Center or Rural Health Clinic applying for this grant program.

(c) "Area of greatest need" means an area identified by the Department as not having sufficient primary care providers to satisfactorily meet medical care demand for the area's population. Areas of greatest need will change regularly and be determined by the Department.

(d) "Cash" means an unobligated liquid asset.

(e) "Certified Electronic Health Record" means an electronic health record that has been certified under the Certified Health IT Product List (CHPL). The CHPL is available at http://onc-chpl.force.com/ehrcert.

(f) "Community Health Center" means a health center receiving federal funding pursuant to Public Health Service Act Section 330 (PHS 330). This does not include other Federally Qualified Health Centers (FQHCs) including, but not limited to, migrant and homeless clinics.

(g) "Department" means the Wyoming Department of Health, Public Health Division, Rural and Frontier Health Section, Office of Rural Health or the contractor/entity utilized to administer the Program.

(h) "Electronic Health Record" means an electronic version of a patient's medical history that is maintained by the provider over time, and may include all of the key administrative clinical data relevant to the patient's care under a particular provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports.

(i) "Grant" means an award of state funds to an applicant through a written Grant Award Agreement.

(j) "Grant Amount" means the Program funds identified in the Grant Award Agreement.

(k) "Grant Award Agreement" means a legally enforceable and binding agreement describing the terms of the commitment between the Department and the grantee.

(l) "Grantee" means an applicant approved for a grant under the Program.

(m) "Grant Term" means a three (3) year Grant Award Agreement and timeframe under which a grantee must adhere to Program requirements.

(n) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

(o) "In-kind" means real property, goods, or services with documented equity equal to or greater than the amount provided as the in-kind local match.

(p) "Integrated care" means the clinic's coordination with other local healthcare professionals, home health agencies, and the patient's hospital, to enhance care, improve access to care, reduce emergency room visits and re-hospitalizations for all patients in the clinic's service area. The clinic uses patient data and best practice guidelines to be proactive in providing quality care to improve patient outcomes, or be recognized as a "patient centered medical home" by a national program.

(q) "Key performance indicators" means quantifiable measurements, agreed to between the Department and grantee prior to executing the Grant Award Agreement, that reflect the critical success factors of the project.

(r) "Local match" means the local funding source, in cash, in-kind, or both, the applicant receives from the local community to apply toward the proposed project and must be no less than twenty-five percent (25%) of the total grant amount.

(s) "New Access Point Grant Application" means the formal Health Resources and Services Administration (HRSA) application process required to become a Community Health Center.

(t) "Operational expenses" means expenses such as, but not limited to, rent, utilities, and salaries.

(u) "PHS 330 funding" means 42 U.S.C. § 254b of the federal Public Health Service Act that provides grants to Federally Qualified Health Centers, including Community Health Centers. This is commonly referred to as PHS 330 funding or 330 funding.

(v) "Program" means the Wyoming Primary Care Support Grant Program.

(w) "Rural Health Clinic" means a certified Rural Health Clinic, as documented by the Centers for Medicare and Medicaid Services (CMS).

(x) "Service Area" means the geographic vicinity a clinic draws the bulk of patients from. This may be a town, city, county, or a combination thereof.

(y) "Sliding fee scale" means a scale to determine whether a patient receives services free of charge, for a nominal fee, or at a discounted rate based upon income and current federal poverty guidelines.

(z) "Treat without reservation" means to not limit the number or type of care for patients qualified under the Medical Assistance and Services Act (Medicaid), Title XVIII of the federal Social Security Act (Medicare), and the Children's Health Insurance Program (CHIP) who seek medical care which the healthcare provider is qualified to provide in the grantee's clinic.

(aa) "This Act" means W.S. § 9-2-127, the Wyoming Primary Care Support Act.

(bb) "Quality Indicators" means financial and clinical quality measures including, but not limited to, those found in the Consolidated List of Performance Measures published by the Bureau of Primary Healthcare (BPHC).

Section 5. Primary Care Support Grants – Terms and Service.

(a) The Department shall issue Grant Award Agreements to the selected applicants. The Agreement shall set forth the terms of the grant, including, but not limited to, the grant amount, grant term, approved project, and payment terms.

(b) The grantee's term of service under the Grant Award Agreement shall be three (3) years from the effective date of the Agreement.

(c) Grantees must comply with all Grant Award Agreement requirements for the entire three (3) year term of the Grant Award Agreement.

(d) Grants are not to be used for operational expenses. If a question arises as to whether an expense is categorized as operational, the Department will make a determination on a case-by-case basis.

Section 6. Department Responsibilities.

(a) The Department shall develop an application form, process and timeline. The Department shall make the application form available in electronic format accessible by the public.

(b) The Department will accept applications on an ongoing basis and make determinations of grant awards within sixty (60) days of grant application submission. The Department may extend this period to ninety (90) days and if the Department does so, the Department will notify the applicant(s) in writing prior to the end of the initial sixty (60) days.

(i) If the Department requires the applicant to clarify information submitted on the application or attachments, the Department will have sixty (60) additional days from the date the written clarification response is received by the Department to make a determination.

(ii) If the Department requires the applicant to clarify information submitted on the application or attachments, the Department will determine the timeline the applicant has to submit the written clarification response. The Department will set a reasonable timeline based on the complexity of the clarification needed.

(iii) The Department may declare an application invalid if multiple clarifications are needed.

(c) The Department will accept applications for funds to facilitate capital construction and start-up costs for Community Health Centers and Rural Health Clinics. Eligible applicants can apply for items identified in Section 2(a) of these Rules.

(i) The Department will determine if the application meets statutory and rule requirements prior to considering the applicant for a grant award.

(ii) Applications that do not meet the statutory mandates or requirements in these Rules will be returned to the applicant with a written explanation.

(d) The Department shall determine the total amount of the grant authorized for each approved application. The grant amount shall not exceed the amount authorized by law regardless of the amount of grant funds requested in the approved application.

(e) The Department shall notify the selected applicants and coordinate the Grant Award Agreement between the grantee and the Department. The Agreement shall set forth the terms of the grant, including, but not limited to, the grant amount, grant term, approved project, and payment terms.

(f) The Department shall make grant payments in the following manner:

(i) An initial, up-front grant payment may be made at the time the Grant Award Agreement is finalized. This initial payment shall not exceed ten percent (10%) of the total grant award amount.

(A) The applicant may submit a request for an initial payment amount over ten percent (10%) of the total grant amount at the time the Grant Award Agreement is finalized. The decision to approve or deny such requests is at the sole discretion of the Department.

(ii) The Department will make the remaining payments based upon invoice from the grantee for completed work as identified in the Grant Award Agreement. Payments, based on the invoices, will be made quarterly.

(iii) The Department will verify that grantees have supplied all required documentation as required under the Grant Award Agreement prior to making payments under the Grant Award Agreement.

(g) In addition to general funds appropriated by the legislature for this Program, the Department may accept gifts, grants, contributions, bequests, and donations to fund this Program. The Department may not use such funds for any other purpose or program.

(h) The Department shall verify grantee's compliance with the Program requirements by reviewing reports supplied by the grantee and information from other entities, together with information from, but not limited to, the federal Health Resources and Services Administration and Centers for Medicare and Medicaid Services, the Wyoming Department of Health Division of Healthcare Financing and Aging Division, Healthcare Licensing and Surveys Section, and community members.

(i) Collect, compile, and maintain the grantees' reports on the grants' effect on improvements to access to care in the community and surrounding rural areas.

(j) Require non-compliant grantees to repay the state an amount as determined by the Department. The grantee shall repay one hundred percent (100%) of grant funds paid by the Department, in addition to all expenses incurred in collection. This repayment shall be completed in a timely manner, pursuant to a written Repayment Agreement and schedule.

(i) Failure to comply with the terms of the written Repayment Agreement and schedule will result in legal action against the grantee.

Section 7. Applicant/Grantee Responsibilities.

(a) The applicant, following public notice and a hearing, must obtain approval by the Board of County Commissioners for the applicable county to apply for these grant funds. A copy of the meeting minutes where board approval was granted is required as part of the application.

(b) Eligible applicants must complete the approved Program application and submit it to the Department within sixty (60) days of the Board of County Commissioners' approval.

(c) During the three (3) year grant term, which will be identified in the Grant Award Agreement, grantees must:

(i) Provide services to the public regardless of an individual's ability to pay, and accept as first priority, and treat without reservation, patients qualified under the Medical Assistance and Services Act (Medicaid), Title XVIII of the federal Social Security Act (Medicare), and the Children's Health Insurance Program (CHIP) who seek medical care which the healthcare provider is qualified to provide. Sliding fee scales and charity care policies based upon income are acceptable. Care is not always expected to be free; however, an unreasonable sliding fee scale or payment policy can be cause for denial of grant funds.

(ii) Submit an annual report to the Department stating the number of patients seen using the clinic's sliding fee scale and/or charity care policy, as well as the number of patients seen using Medicare, Medicaid, and CHIP.

(iii) Integrate care within the entire service community, as described in Section 4 of these Rules, and reflect the integration in the grantee's operation plan. An operation plan that does not reflect integration of services as described in Section 4 is cause for denial of grant funds.

(iv) Maintain HIPAA compliance in all communications pertaining to this Program with the Department.

(v) Annually supply key performance indicators, as defined in Section 4 of these Rules, for the approved project and include a narrative and other supporting documentation on key performance indicator status. Key performance indicators must be approved by the Department and must be consistent with the purpose of this Program, as stated in Section 2 of these Rules.

(vi) Annually collect, maintain, and report data on the grant's effect on improvements to access to care within the community and surrounding rural areas.

(vii) Submit a quarterly report on three (3) quality indicators of the grantee's choosing, as described in Section 4 of these Rules. Indicators must remain the same during the entire three (3) year grant term. Grantee may request in writing to change an indicator. The Department, at its sole discretion, will determine if the requested change is approved or denied.

(viii) Within sixty (60) days of the end of the three (3) year grant term, the grantee must submit an end of grant final report to the Department that summarizes the project's successes, challenges, and outcomes, as well as all required reports and data to date.

(ix) Agree to repay the state all grant funds received if grantee fails to remain in compliance with the terms and requirements of these Rules and the Grant Award Agreement for the entire three year (3) grant term.

Section 8. Eligibility Criteria for Primary Care Support Grant Applicants.

(a) New Community Health Centers are eligible to apply. A new Community Health Center shall include:

(i) An existing clinic that has submitted a 'New Access Point' grant application to receive PHS 330 funding as a federally qualified Community Health Center. This does not include other Federally Qualified Health Centers (FQHCs), including, but not limited to, migrant and homeless clinics.

(ii) A planned or new clinic that will apply for a 'New Access Point' grant to receive PHS 330 funding as a federally qualified Community Health Center. This does not include other Federally Qualified Health Centers (FQHCs), including, but not limited to, migrant and homeless clinics.

(iii) Failure to obtain PHS 330 funding will not automatically disqualify or terminate a clinic's ability to continue to participate in this Program. Failure to obtain PHS 330 funding or designation as a Rural Health Clinic within eighteen (18) months will result in termination of the clinic's participation in the Program, and the clinic must repay the state one hundred percent (100%) of grant funds received from the state.

(b) New Rural Health Clinics are eligible to apply. A new Rural Health Clinic shall include:

(i) An existing clinic that has applied to the Centers for Medicare and Medicaid Services (CMS) to convert to Rural Health Clinic status.

(ii) A newly planned clinic that will apply for Rural Health Clinic status.

(iii) Failure to obtain CMS Rural Health Clinic status will not automatically disqualify or terminate a clinic's ability to participate, or to continue to participate, in this Program. Failure to obtain designation as a Rural Health Clinic within eighteen (18) months will result in termination of the clinic's participation in the Program, and the clinic must repay the state one hundred percent (100%) of grant funds received from the state.

(c) Existing Community Health Centers and Rural Health Clinics, as defined in Section 4 of these Rules, are eligible to apply.

(d) Communities eligible for this Program are the same communities eligible for Rural Health Clinics and Community Health Centers. The Department may utilize commonly available sources to determine community eligibility.

(i) To determine area of greatest need, the Department will utilize the same sources as for other Department 'access to care' programs. The Department will determine the best source of information to utilize for this purpose on an ongoing basis.

(e) All applicants must have a CHPL-certified electronic health record, as defined in Section 4 of these Rules.

Section 9. Application Process.

(a) The Department shall develop an application form, and make it available in electronic format accessible by the public.

(b) The application period will be open and ongoing.

(c) The Department will make a notification of grant award within sixty (60) days of an applicant's submission or notify the applicant(s) in writing, as identified in Section 6 of these Rules.

(d) Prior to submission of the Primary Care Support Grant Program application to the Department, the applicant, following public notice and a hearing, must obtain approval by the Board of County Commissioners for the applicable county. An official copy of the meeting minutes obtained from the County Clerk of the applicable county is required as part of the application. The meeting minutes must state that board approval was granted.

(e) Within sixty (60) days of receipt of approval from the Board of County Commissioners, applicant must complete the approved application and submit it to the Department with the appropriate and required supporting documents.

(f) The application, among other documents and factors as outlined in these Rules and in the statute, will be used to determine if an applicant is awarded a grant and must:

(i) Include a narrative describing the scope of the project.

(ii) Identify the location and physical address of the current or projected clinic as applicable.

(iii) Identify and document the availability of local matching funds in an amount no less than twenty-five percent (25%) of the total funding request. For example, a grant request of $400,000 must show $100,000 in local matching funds.

(A) Local matching funds may be in cash, in-kind, or both, and must be shown in the form of a contract, promissory note or other legally binding written agreement.

(B) Local matching funds must be utilized proportionally to the grant funds as the project progresses. A timeline shall be developed to include within the Grant Award Agreement, setting forth the proportional use of the funds, which may differ with the requirements of different projects.

(iv) Identify the itemized total cost of the intended project, the total grant amount requested, and the total local matching funds (cash or in-kind).

(A) If local matching funds are in-kind, an appraisal of goods and services must be included with the application.

(B) In the event there is disagreement in the value of in-kind match, the Department may pursue alternative means to determine the in-kind value. If there is a cost to determining this value, that cost will be billed to and paid for by the applicant. A considerable difference in value is cause for denial of a grant, and is within the discretion of the Department.

(v) Identify how the applicant will provide services to individuals regardless of their ability to pay and provide care to Medicare, Medicaid, and CHIP eligible patients. The applicant must submit the charity care policy or sliding fee scale, or both, with its application.

(vi) Provide an operating plan that integrates healthcare services within the entire service community to promote accessibility and quality of care as is required by this Act.

(vii) If applicable, demonstrate how an existing clinic positively impacts access to care.

(viii) If applicable, justify creation of a new clinic in the community identified.

(ix) Identify how the applicant's proposal may reduce Emergency Room or similar type care usage.

(x) Identify three (3) quality indicators of the applicant's choice, as defined in Section 4 of these Rules.

(xi) Identify a list of key performance indicators for the project, as defined in Section 4 of these Rules.

(xii) Demonstrate how the applicant will meet reporting requirements to remain in compliance with the Program during the entire three (3) year grant term.

(xiii) Identify the individual responsible for the entity, including the chairperson, CEO, board of directors, or equivalent if a public entity, or owner(s) if not a public entity. If awarded a grant under this Program, the entity must notify the Department of any changes to the ownership, organization or control of the entity. The Department shall review the change and determine what, if any, effect the change in ownership, organization or control may have on the Program and the funding. The Department retains the sole discretion to refuse to fund an organization that has changed ownership, organization or control after the initial application period, and retains the ability to request repayment of one hundred percent (100%) of Program funds should there be a change of ownership, organization or control.

(xiv) Include a copy of the Board of County Commissioners' meeting minutes where approval was given to the entity to apply for this Program.

Section 10. Selection Process.

(a) The Department will develop a committee within the Department to select applicants that best meet the state's need for increased access to integrated care. The committee may include partners from outside the Department.

(b) Selection criteria shall include, but may not be limited to:

(i) Highest priority will be given to applications for clinics in areas of greatest need for primary care access, as determined by the Department;

(ii) Potential of the project to increase primary care access in the applicable community and surrounding areas;

(iii) A new primary care clinic in a community where access to care does not exist shall have higher priority than existing clinics changing status or new clinics not in areas of greatest need;

(iv) Non-profit clinics shall be considered higher priority than for-profit clinics;

(v) The Department shall use information from the application form and other sources in the selection process;

(vi) The Department shall make awards only to applicants who, in the opinion of the Department, have well documented and executable plans for integrated care.

(vii) The Department shall make awards only to applicants who, in the opinion of the Department, have a project scope that is well supported by the financial plan included in the application for funding.

(viii) The Department shall make awards only to applicants who, in the opinion of the Department, have a good operation plan that is supported by a good business model.

(ix) Service areas without existing eligible Community Health Centers will be given priority over service areas with existing eligible Community Health Centers.

(x) Service areas without existing eligible Rural Health Clinics will be given priority over service areas with existing eligible Rural Health Clinics.

Section 11. Primary Care Support Grant Program Breach, Repayment and Penalties.

(a) A grantee who fails to complete or comply with the requirements of the Program, these Rules, or the Grant Award Agreement shall:

(i) Repay the state, according to a schedule established by the Department and provided in a Repayment Agreement, the full amount of grant funds received under the Program as of the date of the breach. The Department may include in the Repayment Agreement any costs and expenses incurred in collecting these amounts, including attorney fees and other litigation and court costs.

(A) At the written request of the grantee, the Department may consider approving a lower repayment amount based upon the date of the default and overall compliance with the intent of this Act as verified in submitted reports. This reduction shall be at the sole discretion of the Department.

(ii) Amounts recovered and damages collected under this section shall be deposited to the Primary Care Support Account to be used to carry out the provisions of this Act.

(b) In the event the local matching funds are withdrawn, the Grant Award Agreement shall be terminated, and the grantee shall be required to repay the state all grant funds received up until the date of termination in accordance with a written Repayment Agreement and schedule established by the Department.

(c) At the written request of the grantee, the Department may cancel or release, in full or in part, a grantee from the requirements of the Program and the Grant Award Agreement without penalty under the following circumstances:

(i) The grantee is unable to fulfill the requirements of the Program and the Grant Award Agreement due to natural, man-made, or other event that prevents or significantly disrupts clinic operation at the identified location for a period of eighteen (18) consecutive months during the three (3) year grant term.

(ii) For other good cause shown, as requested by the grantee and approved by the Department, at its sole discretion.

(d) The Department may allow for a transfer of clinic location to another approved site in order to allow grantee to fulfill the terms and requirements of the Program and Grant Award Agreement.

(e) Upon receipt of written request for waiver of breach, repayment and penalties or transfer, the Department shall review and provide a written decision on the request to the grantee.

Section 12. Reporting Requirements.

(a) The grantee's reporting requirements are discussed in Section 7 of these Rules and will be incorporated into the Grant Award Agreement between the Department and the grantee.

(b) The Department may require grantee to provide additional information or reports on a regular basis (monthly, quarterly, semi-annually, or annually) and the requirements for such shall be set forth in the Grant Award Agreement between the Department and the grantee.