Certification Page
Regular and Emergency Rules

1. General Information

a. Agency/Board Name *See attached list for references*
Wyoming Department of Health

b. Agency/Board Address	c. Agency/Board City	d. Agency/Board Zip Code
6101 Yellowstone Road, Suite 210	Cheyenne	82002

e. Name of Contact Person	f. Contact Telephone Number
Chris Bass	307-777-6029

g. Contact Email Address	h. Adoption Date:
chris.bass@wyo.gov	March 19, 2012

i. Program(s) *See attached list for references*
Medicaid

2. Rule Type and Information

a. These rules are: ☐ **Emergency Rules** *(After completing all of Section 2, proceed to Section 5 below)* ☒ **Regular Rules**

b. Choose all that apply: ☒ **New Rules*** ☒ **Amended Rules** ☒ **Repealed Rules**

** "New" rules means the first set of regular rules to be promulgated by the Agency after the Legislature adopted a new statutory provision or significantly amended an existing statute.*

If "New," provide the Enrolled Act number and year enacted: 2011 HEA0054

c. Provide the Chapter Number, and Short Title of Each Chapter being Created/Amended/Repealed *(if more than 5 chapters are being created/amended/repealed, please use the Additional Rule Information form and attach it to this certification)*

Chapter Number:	Short Title:
7	Wyoming Nursing Home Reimbursement System
17	Nursing Facility Resident Trust Accounts
19	Nursing Facility Preadmission Screeings
23	Cost Incurred by NH in Implementing the OBRA/87 Requirements - Repealed
28	Swing-bed Services

d. ☒ The Statement of Reasons is attached to this certification.

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

3. State Government Notice of Intended Rulemaking

a. Date on which the Notice of Intent containing all of the information required by W.S. 16-3-103(a) was filed with the **Secretary of State**:	January 5, 2012
b. Date on which the Notice of Intent and proposed rules in strike and underscore format were provided to the **Legislative Service Office**:	January 5, 2012
c. Date on which the Notice of Intent and proposed rules in strike and underscore format were provided to the **Attorney General**:	January 5, 2012

4. Public Notice of Intended Rulemaking

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

b. A public hearing was held on the proposed rules. ☐ Yes ☒ No

If "Yes:"	Date:	Time:	City:	Location:

5. Final Filing of Rules

a. Date on which the Certification Page with original signatures and final rules were sent to the **Attorney General's Office for the Governor's signature**: March 19, 2012

b. Date on which final rules were sent to the **Legislative Service Office:** March 19, 2012

c. Date on which a PDF of the final rules was electronically sent to the **Secretary of State**: March 19, 2012

6. Agency/Board Certification

The undersigned certifies that the foregoing information is correct.

Signature of Authorized Individual	Thomas O Forslund
Printed Name of Signatory	Thomas O. Forslund
Signatory Title	Director, Wyoming Department of Health
Date of Signature	March 19, 2012

7. Governor's Certification

I have reviewed these rules and determined that they:

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

Therefore, I approve the same.

Governor's Signature	
Date of Signature	

Distribution List:

Attorney General

1. Statement of Reasons;
2. Original Certification Page;
3. Summary of Comments (regular rules);
4. Hard copy of rules: clean and strike/underscore; and
5. Memo to Governor documenting emergency (emergency rules).

LSO

1. Statement of Reasons;
2. Copy of Certification Page;
3. Summary of Comments (regular rules);
4. Hard copy of rules: clean and strike/underscore;
5. Electronic copy of rules: clean and strike/underscore; and
6. Memo to Governor documenting emergency (emergency rules).

SOS

1. PDF of clean copy of rules; and
2. Hard copy of Certification Page as delivered by the AG.

CHAPTERS 7, 17, 19, 23, 28

Rules and Regulations for Wyoming Medicaid

Statement of Reasons

The Wyoming Department of Health proposes to adopt the following Amended Rules to comply with the provisions of W.S. § 42-4-101, *et seq*., and the Wyoming Administrative Procedure Act at W.S. § 16-3-101, *et seq*.

The Department is promulgating these Rules to be compliant with federal rules and regulations. These Rules will establish and clarify guidelines for the administration and operation of the Wyoming Medicaid program.

All the below chapters have been edited to follow the desire of the Department to establish consistent definitions across all chapters of Medicaid Rules.

Chapter 7 (Nursing Home Reimbursement System) is edited to reflect a change to the rate effective date for nursing home rate setting. Language was also added to speak to the new Facility Assessments that will occur as a result of HB0193, which was passed in the spring 2011 legislative session.

Chapter 17 (Nursing Facility Residence Trust) is promulgated in response to the desire of the Department to establish consistent definitions across all chapters of Medicaid Rules. No other changes were made to this Chapter.

Chapter 19 (Nursing Facility Preadmission Screenings) is edited to make changes directly related to the definition change from Mentally Retarded to Intellectually Disabled.

Chapter 23 (Reimbursement of Costs Incurred by Nursing Homes in Implementing the OBRA /87 Requirements) is being repealed due to no longer being required for nursing facility reimbursement as the special reporting provisions were used for rate add-ons up to July 1, 1993. The additional costs related to the provisions of OBRA are no longer reimbursed as an add-on and the costs are included within all other nursing facility costs.

Chapter 28 (Swingbed Services) is edited to more clearly state the requirements of a Level II PASRR being required and its exceptions to Chapter 19 in a swing bed.

As required by W.S. § 16-3-103(a)(i)(G), these Chapters of the Wyoming Medicaid Rules meet minimum substantive state statutory requirements.

WYOMING MEDICAID RULES

CHAPTER 7

WYOMING NURSING HOME REIMBURSEMENT SYSTEM

Section 1. Authority.

This Chapter is promulgated by the Department of Health pursuant to the Medical Assistance and Services Act at W.S. § 42-4-101, *et seq*., and the Wyoming Administrative Procedure Act at W.S. § 16-3-101, *et seq*.

Section 2. Purpose and Applicability.

(a) This Chapter has been adopted to establish methods and standards for Medicaid reimbursement rates for nursing facilities which provide services to clients. It shall apply to and govern all payments of Medicaid funds to facilities for services furnished on or after October 1, 2009.

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

(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.

(d) Effective with rates beginning on October 1, 2010, nursing facilities shall remain at the finalized rate paid beginning October 1, 2009.

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

Section 4. General Provisions.

(a) Cost terms and hierarchy. This rule includes the following cost terms, even though such cost may not be reimbursable because of other provisions of this rule, in the following hierarchy:

(i) General ledger cost. A cost properly recorded on a nursing facility's general ledger in accordance with GAAP. This includes cost incurred at an individual nursing facility as well as central office or pooled cost reasonably allocated to

an individual nursing facility;

(ii) Reported cost. General ledger cost properly reported on the cost report. It is composed of allowable cost and nonallowable cost;

(iii) Non-allowable cost. Cost which is not reasonably related to covered services; and

(iv) Allowable cost, as defined in the Rules and Regulations for Wyoming Medicaid, Chapter 1, Definitions.

(b) General methodology.

(i) Costs related to direct patient care are more likely to benefit quality of patient care than indirect costs.

(ii) Costs incurred in the actual delivery of patient care are more likely to contribute to the quality of care offered by a nursing facility than costs incurred at a distance from the delivery of services.

(iii) To be allowable, costs must be reasonable, ordinary, necessary and related to patient care. Providers shall incur costs in such a manner that economical and efficient delivery of quality health care to participants will result.

(iv) Except as otherwise specified in this Chapter, the Department shall determine per diem rates using the methodology set forth in the Medicare Provider Reimbursement Manual ("PRM") and CMS instructions for administering the PRM. The PRM and the CMS instructions are published by CMS and are available from that agency.

Section 5. Submission and Preparation of Cost Reports.

(a) Time of submission. Complete cost reports shall be submitted by the end of the fifth (5^{th}) month following the provider's fiscal period end.

(i) Complete cost report. A cost report shall be deemed complete upon receipt of the completed and certified cost report and the information specified in subsections (c)(iii)(A-J). The per diem rate shall not be computed, however, until the receipt of the information specified in subsections (c)(iii)(A-J). The Department may request additional information, in writing, by certified mail, return receipt requested. Any such information must be submitted, by certified mail, return receipt requested, within thirty (30) days after the date of the request. A cost report may not be amended after submission.

(ii) Extension. A thirty (30) day extension of the submission date shall

be granted by the Department for good cause if requested by a provider, in writing, prior to the due date. A cost report shall not be deemed past due while an extension term is in effect. Only one (1) request for an extension may be granted for each cost reporting period.

(b) Failure to timely submit cost report. If a cost report, including the information specified in subparagraphs (c)(iii)(A-J) and any information requested pursuant to paragraph (a)(i), is more than ten (10) days past due, the Department shall reduce the per diem rate by twenty-five (25) percent until all missing information is received in writing in the form specified by the Department. If the cost report, including the information specified in subparagraphs (c)(iii)(A-J) is more than sixty (60) days past due, the Department shall suspend all Medicaid payments until all missing information is received in writing in the form specified by the Department. Upon receipt of a complete cost report that has been prepared in accordance with these rules, the penalty will be refunded, without interest. This remedy does not affect the Department's right to withhold per diem payments, terminate provider participation or invoke other remedies permitted by applicable statutes and rules.

(c) Preparation of cost reports.

(i) Cost reporting must be reasonable and consistent within a nursing facility, between Medicaid certified and noncertified parts where such distinction is utilized for cost finding, among multiple facilities under the same ownership or control, and over time.

(ii) Allocation of costs. Costs must be allocated pursuant to the cost report.

(iii) Required information. Authenticated copies of significant agreements and other documentation must be attached to the cost report. This material includes:

(A) Contracts or agreements involving the purchase of facilities or equipment during the last seven (7) years, unless previously submitted;

(B) Contracts or agreements with owners or parties related to the provider, unless previously submitted;

(C) Leases regarding real or personal property, unless previously submitted;

(D) Management contracts, unless previously submitted;

(E) Mortgages and loan agreements, unless previously submitted;

(F) Working trial balance actually used to prepare cost report with line number tracing notations or similar identifications;

(G) Audit, review or compilation statements prepared by an independent accountant that includes nursing facility costs or allocation of costs to the nursing facility, including disclosure statements and management letters or SEC Forms 10-K;

(H) Home office cost statement;

(I) Medicare cost report; and

(J) Any other document, requested, in writing, by the Department, relating to the provision of services, the submission of claims for reimbursement or a nursing facility's cost reports.

(iv) If any document is not submitted with the cost report, an explanation must be attached to the cost report and subsection (b) shall apply.

(v) Changes in a nursing facility's reporting methods are permissible only when written application is received by the Department prior to the end of the cost report period. The Department shall approve the change if it can reasonably be expected to result in more accurate reporting.

(vi) Fiscal period. A provider shall adopt the same fiscal period for completing the cost report as the nursing facility uses for reporting Medicare costs.

(A) If a provider is not certified by Medicare, the nursing facility's Medicaid cost reporting period shall be the same period the nursing facility uses for federal income tax reporting.

(B) Normally, a fiscal period will be twelve (12) months in length. It may be less than twelve (12) months because of changes in the nursing facility's Medicare cost reporting period. For purposes of nursing facility rate-setting, cost report periods of less than six (6) months will not be used.

(vii) Determination of allowable costs. The Department shall determine a nursing facility’s allowable cost within ninety (90) days of the Department’s receipt of the nursing facility’s cost report and all information required by section 5(c)(iii)(A-J) of this Chapter. These costs will be utilized to set the rate pursuant to Section 17 of this Chapter.

(d) Certification of cost reports.

(i) General requirement. The provider must certify the accuracy and validity of the cost report.

(ii) Who may certify. Certification must be made by a person authorized by the governing body of the nursing facility to make such certification. Proof of such authorization shall be furnished upon request by the Department.

(A) If the provider is a corporation, an officer of the corporation must certify;

(B) If the provider is a general or limited partnership, a general partner must certify;

(C) If the provider is a sole proprietorship or sole owner, the owner must certify;

(D) If the provider is a public nursing facility, the chief administrative officer of the nursing facility must certify; or

(E) If the provider is any other entity, the person certifying must be approved in writing by the Department before the certification.

(iii) Certification statement. The cost report must contain the following certification statement:

> Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and/or imprisonment under state or federal law.
>
> I hereby certify that I have read the above statement and I have examined the accompanying cost report and supporting schedules prepared by (Provider name and number) _____ for the cost report beginning _____, 20___, and ending _____, 20___, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.
>
> _____ _____ _____
> Signature Title Date

(e) Substitute cost report forms. If a nursing facility desires to submit its cost report on forms other than those specified by the Department, the nursing facility must submit such substitute forms to the Department for approval in advance of their use. To be approved, such forms must be accompanied by a letter which represents that each page of the substitute form is the same size and has the same general appearance as the

Department's cost report, and that all form and data elements are present and appear in the same location and sequence on each page as on the Department's cost report. If approved, the Department shall issue an approval letter. Each use of substitute forms shall require a reference to the date of the Department's approval letter and indicate the substitute form's sponsor.

Section 6. Joint Use of Resources.

(a) Multiple business enterprises. If a provider owns, controls or manages multiple business enterprises, the revenues, expenses, statistical and financial records of each separate enterprise shall be clearly identifiable. If a field audit or desk review establishes that the provider's records do not clearly identify the information required by this rule, none of the commingled cost shall be an allowable cost for purposes of the nursing facility's per diem rate.

(b) Control, ownership or management by third party.

(i) Separate records. When the nursing facility is owned, controlled or managed by a person or entity that owns, controls or manages one (1) or more other nursing facilities, records of central office and other costs incurred outside the nursing facility shall be maintained so as to separately identify revenues and expenses of, and allocations to, individual facilities.

(ii) Allocation of pooled costs shall be reasonable and conform to GAAP, the provisions of this rule, and the instructions of the Department. Pooled cost is allowable only to the extent that the pooled cost is incurred in providing patient-related services and the provider can demonstrate that pooled cost improves efficiency, economy, or quality of care. All patient-related pooled costs allocated to a nursing facility that meet these requirements shall be reported in the operating cost component.

(iii) Direct patient service costs. Direct patient service costs incurred by multiple nursing facility organizations may be reported in the health care component if the service was rendered to the client at the nursing facility and is separately identified, rather than allocated, in the provider's accounting records. Patient service costs which do not meet these criteria must be reported in the operating cost component.

Section 7. Per Diem Rate Determination.

(a) New nursing facilities. A newly constructed facility, a newly designated portion of a hospital which has not previously been designated as a facility, or an existing facility which has not previously been certified. An addition to a certified facility is not a "new facility."

(i) A new nursing facility shall receive an initial rate determined pursuant to subsection 17(c).

(ii) A new nursing facility's initial rate will be effective until the end of the first fiscal year ending six (6) or more months after the certification date, at which time the Department shall establish a per diem rate pursuant to this rule. This per diem rate will also be utilized as the facility's base rate.

(b) Change of ownership.

(i) A nursing facility which has a change of ownership shall receive the per diem rate in effect for that nursing facility on the date of the change of ownership. This per diem rate shall remain in effect until the end of the first fiscal year ending six (6) or more months after the date of the change of ownership, at which time the Department shall establish a per diem rate pursuant to this rule.

(ii) Record keeping requirements. The former owner shall be responsible for maintaining all medical and financial records for one (1) year after the date of the change of ownership. If the nursing facility is involved in an audit or administrative or judicial proceedings which require access to such records, the records must be maintained for one (1) year after completion of all proceedings, including any applicable appeal periods.

(c) Other facilities. The per diem rate for facilities other than a new facility or those without a change of ownership shall be established pursuant to the provisions of this Chapter.

(d) Effective dates of per diem rates. Per diem rates are established prospectively and shall remain in effect from the rate effective date until redetermined pursuant to this rule.

Section 8. Medicaid Reimbursement for Reserve Bed Days.

(a) Reserved bed days.

(i) Facilities may receive the per diem rate for reserved bed days during temporary absences if an appropriate bed is not available during the time for which reimbursement is sought.

(ii) Reimbursement for temporary absences is limited to fourteen (14) days per calendar year.

(iii) If a nursing facility maintains an average occupancy of ninety (90) percent or more within the month of the leave, the nursing facility may receive the per diem rate for reserved bed days during temporary absences. Occupancy is calculated as total patient days (period of service rendered to a patient, not including any day that a patient was temporarily absent), divided by licensed beds, multiplied by the number of

calendar days in the period being measured.

(iv) A provider may not bill a client or the client's family for reserved bed days that are not reimbursed pursuant to this section unless the nursing facility has informed the client, in writing, before the period for which reimbursement is sought of the client's option to make payments to hold the bed if the temporary absence exceeds the period for which Medicaid reimbursement is available.

Section 9. Cost Components.

(a) General requirements. Costs shall be allocated among the following cost components as specified in this section: (1) health care costs; (2) capital costs; and (3) operating costs. For purposes of this section, "labor costs" includes the cost of employee benefits and taxes. Services and supplies used in providing patient-related services include, but are not limited to, those specified in Attachment A.

(b) Health care cost component. The health care cost component consists of the following costs provided such costs are direct costs of patient-related services actually rendered within the nursing facility (or direct patient-related services provided outside the nursing facility, if medically necessary) and the cost of related supplies actually used in the nursing facility:

(i) Activities, including direct labor cost;

(ii) Dietary, including direct labor cost;

(iii) Direct health care labor costs for the following:

(A) Health care education, including OBRA '87 nurse aide training requirements;

(B) Licensed practical nurses;

(C) Medical director;

(D) Nurse assistants;

(E) Nursing administrators;

(F) Nursing consultants;

(G) Registered nurses; and

(H) Rehabilitation personnel.

(iv) Services and supplies included in the per diem rate (reduced by the cost of services paid from other sources);

(v) Social services, including direct labor cost; and

(vi) Travel costs related to the above.

(c) Capital cost component. The capital cost component consists of the following costs:

(i) Leasehold amortization;

(ii) Rent/lease expense;

(iii) Depreciation; and

(iv) Interest on real estate and personal property.

(d) Operating cost component. The operating cost component consists of:

(i) Housekeeping, including direct labor cost;

(ii) Laundry, including direct labor cost;

(iii) Medical records;

(iv) Patient-related administrative costs (including home office and management fees which are not health care costs under subsection (b));

(v) Plant operations and equipment costs; and

(vi) Travel costs related to the above.

Section 10. Determination of Capital Cost.

(a) Depreciation.

(i) The depreciation of a tangible asset used to deliver patient-related services is an allowable cost if the asset is:

(A) In use;

(B) Identifiable to patient care;

(C) Available for physical inspection; and

(D) Recorded in the provider's records.

(ii) Basis. The basis used in calculating depreciation shall be the historical cost of the asset, which is the cost incurred by the present owner in acquiring the asset and preparing it for its use. Generally such cost includes costs that are capitalized under GAAP. For example, in addition to the purchase price, historical cost includes architectural fees, consulting fees, and related legal fees.

(iii) Method. Depreciation must be reported on the straight-line method.

(iv) Useful life. Useful life shall be determined in accordance with the most recent edition of Estimated Useful Lives of Depreciable Assets, as published by the American Hospital Association.

(v) If a single asset or collection of like assets acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an estimated useful life of at least two (2) years and historical cost of at least five hundred dollars ($500.00), the cost shall be depreciated over the useful life of the asset.

(vi) Patient-related items that do not qualify for the above definition shall be expenses in the year acquired.

(vii) Donated assets.

(A) Definition. An asset is donated to the extent the provider acquired the asset without paying fair market value in cash, property or services.

(B) Basis. The basis of donated assets, except for donations between providers or from a party related to the provider, is the asset's fair market value, minus the value the provider gave for the asset. If the fair market value of the asset is over two thousand dollars ($2,000.00), the basis shall be the lesser of the appraised value and the fair market value. If the donor is related to the provider, the basis shall be the lesser of the net book value of the donor and fair market value.

(C) Cash donations. Cash donations shall be treated as revenue, and not as an offset to expense accounts.

(b) Permanent Financing Interest. Permanent Financing Interest is financing attendant to the acquisition of patient-related tangible assets.

(i) Allowable cost. Permanent financing interest incurred on patient-related real property, improvements to real property, buildings, building components and equipment is an allowable cost subject to the limitations of this subsection.

(ii) Maximum allowable interest rate. The allowable interest rate on permanent financing from a party related to the provider shall not exceed the Federal Home Loan Mortgage Corporation, Whole Loan Purchase, Multi-Family rate in effect on the date the loan commitment was signed by the lender and borrower.

(iii) Maximum allowable interest expense. The principal amount of permanent financing shall not exceed the allowable historical cost of the facilities and equipment.

(iv) Investment income offset. Interest allowable pursuant to this section must be reduced by investment income pursuant to the PRM.

(v) Reporting requirements. Interest expense must be supported by a written loan agreement, showing that funds were borrowed, payment of interest and repayment of principal is required, and funds were used to purchase patient-related real property, buildings, building components and equipment. The lender, purpose, principal amount, terms and interest rate must be identifiable in the provider's financial records.

(c) Lease and rental expense.

(i) Allowable cost. Lease or rental expenses incurred on patient-related real property, buildings, building components and equipment are an allowable cost subject to the limitations of this subsection.

(ii) Maximum allowable. Leases, rental agreements, and contracts involving the use of real or personal property shall be subject to the same maximum capital component limit as owners of property.

(iii) Related parties. If a provider rents, leases or purchases patient-related real property, buildings, building components and equipment from a party related to the provider, the historical cost to the related party, not to exceed fair market value, shall be utilized in computing the allowable capital cost.

(d) Amortization of leasehold improvements.

(i) Allowable cost. Lease or rental expenses incurred on patient-related real property, buildings, building components and equipment are an allowable cost subject to the limitations of this subsection.

(ii) Amortization of leasehold improvements shall be calculated and reported in accordance with GAAP and are a capital cost.

(iii) Amortization of organizational cost shall be reported in the operating cost component.

Section 11. Determination of Operating Cost Component.

(a) Working capital interest. Working capital interest is patient-related financing other than permanent financing.

(i) Generally. Interest on working capital loans is an allowable cost only if the loans were costs that must be incurred to provide patient-related services.

(ii) Limitation. Interest on working capital loans may not exceed the actual reported interest less any investment income revenue.

(iii) Reporting. Interest on working capital loans shall be reported as an operating cost.

(b) Compensation for services from owners or parties related to the provider.

(i) Compensation for services from an owner or a party related to the provider is an allowable cost if such services were:

(A) Actually performed;

(B) Necessary to the delivery of patient-related services; and

(C) The compensation paid was reasonable.

(ii) Documentation. A provider must maintain written documentation of the time and work performed, the relationship of the work to patient care, whether such work was performed at the nursing facility or outside the nursing facility, and the compensation paid for such work.

(iii) Maximum allowable. Compensation of an owner or party related to the provider is not an allowable cost to the extent it exceeds the median range for comparable services as contained in the most recent survey of administrative salaries paid to persons other than owners of proprietary and nonproprietary providers conducted by the Bureau of Health Insurance and published in the Medicare Provider Reimbursement Manual PRM Part 1, Section 905.2.

(A) Part-time employees. For individuals who work less than a forty (40) hour work week, the maximum allowable amount shall be reduced by the ratio of actual number of hours worked per week to forty (40).

(B) Full-time employees. Individuals who work more than a forty (40) hour work week may have their total salary expenses reviewed for reasonableness. The total salary for that job classification will be compared to industry

averages for that position. Any amounts that appear to be excessive as compared to industry averages will be adjusted to a reasonable amount.

Section 12. Cost of Services and Supplies not Included in the Per Diem Rate.

(a) Services and supplies which are not included in the per diem rate include, but are not limited to:

(i) Ambulance services;

(ii) Audiology services;

(iii) Barber and beauty shop services other than routine personal hygiene items and services;

(iv) Cigarettes, cigars, pipes and tobacco;

(v) Clothing;

(vi) Cosmetics;

(vii) Dental services (unless under purchase for service contract);

(viii) Dry cleaning;

(ix) Eye examinations and other optical supplies and services;

(x) Hearing aids;

(xi) Hospital services;

(xii) Laboratory services;

(xiii) Orthotic services;

(xiv) Physician services;

(xv) Podiatry services;

(xvi) Prosthetic devices;

(xvii) Ventilators; and

(xviii) Customized wheelchairs that are fitted or fabricated to a specific individual and cannot be used by any other person, and electric wheelchairs, including

batteries.

(b) The cost of services and supplies not included in the per diem rate shall be removed from patient-related cost.

(c) Costs not related to patient care are costs that are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Costs which are not necessary may include, but are not limited to, costs that are not usual, common, and accepted occurrences in the field of the provider's activity.

(d) The method of removal depends on a provider's accounting and other records. If a provider has adequate segregation in accounting records, such adjustment shall be based on the cost of services or supplies not included in the per diem rate. If a provider does not maintain adequate cost segregation or if such accounts cannot reasonably be subjected to normal audit procedures, then the related revenue shall be used as an adjustment to patient expense, provided the related revenue amount is reasonably equal to or greater than cost. If these conditions are not met, the entire group of aggregated ancillary or other revenue accounts, or aggregated ancillary or other cost accounts, if greater, shall be used as an offset to patient expenses.

Section 13. Rate Period.

(a) Effective date. For nursing facility services effective on or after October 1, 2009, a provider's per diem rate shall become effective on the rate effective date, which is October 1 of each year. Per diem rates are established prospectively and shall remain in effect from the rate effective date until redetermined pursuant to this rule.

(b) Effective period of rate. A facility shall be bound by the per diem rate until a new rate is computed pursuant to this rule, unless the rate is changed as the result of a desk review or field audit.

(c) Applicable cost report data. The cost data used in establishing the rate calculation effective each October 1 is from the cost reports which ended during the previous calendar year (for example, cost reports ending during the period from January 1, 2008 to December 31, 2008, will be used in setting rates effective October 1, 2009).

(d) Notice of rate. The Department shall notify providers of the per diem rate by certified mail, return receipt requested.

(e) If the desk review or audit of the cost report used to set the rate effective October 1 of each year is not complete when the rate is due to be issued, an interim rate will be issued based on the reported cost. When the review is complete, the rate will be revised and issued as final. Any amounts paid pursuant to the interim rate which exceed the final rate shall be overpayments and shall be recovered pursuant to Section 31 of this

Chapter. If the interim rate is less than the final rate, the Department shall pay the difference to the provider within sixty (60) days.

Section 14. Creation of Database.

(a) Creation of database. Each year the Department shall create a database using the latest complete desk reviewed cost reports for each provider. "Latest complete" means the cost report used to compute the provider's most recent per diem for the applicable year.

(b) Adjustment of cost reports. Cost reports included in the database shall be adjusted so that transactions with owners or parties related to providers are limited pursuant to this rule. Per diem cost report information for the capital cost component shall be subject to a minimum occupancy of ninety (90) percent.

(c) Each year the Department shall create a database which reflects the quality of care and the average level of care provided in facilities.

Section 15. Determination of Medians.

(a) Median health care cost. Using the database created pursuant to Section 14 of this Chapter, the median health care cost shall be determined by arraying the inflation-adjusted allowable per-diem health care cost for each provider, from low to high, and selecting the cost associated with the median licensed bed.

(b) Median operating cost. Using the database created pursuant to Section 14 of this Chapter, the median operating cost shall be determined by arraying the inflation-adjusted allowable per-diem operating cost for each provider, from low to high, and selecting the cost associated with the median licensed bed.

(c) Median capital cost. Using the database created pursuant to Section 14 of this Chapter, the median capital cost shall be determined by arraying the inflation-adjusted allowable per-diem capital cost for each provider, from low to high, and selecting the cost associated with the median licensed bed.

Section 16. Cost Component Limitations.

(a) The Department shall, on or before September 1 of every year, determine limitations for each cost component in accordance with this rule using the database created pursuant to Section 14 of this Chapter, and the medians determined pursuant to Section 15 of this Chapter.

(b) Capital costs. Capital costs shall not exceed the maximum allowable as determined pursuant to Section 18 of this Chapter.

(c) Health care costs. Health care costs shall not exceed one hundred twenty-five (125) percent of the median health care cost.

(d) Operating costs. Operating costs shall not exceed one hundred five (105) percent of median operating costs.

(e) Effective period of limitations. The cost component limitation shall be effective for rate effective dates from October 1 through September 30 of each subsequent year. Cost component limitations shall not be redetermined to reflect changes in facilities allowable costs that result from reconsideration, administrative appeals or judicial decisions.

Section 17. Determination of Per Diem Rate.

(a) Except as otherwise provided in this Chapter, the Department shall determine per diem rates to be effective for services furnished on or after October 1, 2009, as follows:

(i) Per diem rate. The Department reimburses facilities providing nursing facility services, as defined by 42 U.S.C. 1396d(f), to clients using the per diem rates established pursuant to this Chapter.

(ii) Calculated rate. The Department shall establish a calculated per diem rate for each nursing facility pursuant to this Chapter, using that nursing facility's most recent Medicaid cost report for the period ending in the previous calendar year.

(iii) Minimum per diem rate. The Department shall establish a minimum per diem rate for each nursing facility. The minimum per diem rate shall be the nursing facility's base rate, minus the capital component of that rate, plus the capital component of the nursing facility's calculated rate. The minimum rate shall be the rate paid if it is greater than the calculated rate.

(A) The base rate is the per diem rate in effect for a nursing facility on June 30, 2005.

(B) The base rate for a new facility as defined in Section 7(a) will be the first per diem rate established pursuant to this Chapter.

(iv) Maximum per diem rate. The Department shall establish a maximum per diem rate for each nursing facility. The maximum per diem rate shall be:

(A) The base rate, minus the capital component of that rate, multiplied by one hundred ten percent (110%) of the inflation factor, as published quarterly by DRI/McGraw-Hill as the Market Basket and as measured from the mid-point of the base rate to the mid-point of the current rate period; plus

(B) The capital component of the calculated rate.

(C) The maximum rate shall be the rate paid if it is less than the calculated rate.

(b) New facilities. A new nursing facility shall receive a per diem rate equal to one hundred ten (110) percent of the median per diem rate in effect as of the most recent October 1st, except that the capital component of the rate shall be the median allowable capital cost currently in effect in Wyoming.

(c) Application of cost component limitations. The provider's reimbursable rate is the lesser of the provider's inflated allowable cost or the cost component limitations established pursuant to Section 16 of this Chapter.

(d) Maximum per diem rate. A provider's per diem rate shall be the lesser of the rate determined pursuant to this Chapter or the nursing facility's private pay rate.

(e) Except as otherwise specified in (a), a provider shall receive one (1) rate change per year on the rate effective date, unless:

(i) The rate is changed as the result of a desk review or field audit; or

(ii) Changes in federal or state statutes or regulations cause increases in health care costs, as defined in subsection 9(b) of this Chapter, or operating costs, as defined in subsection 9(d) of this Chapter, in which case the Department shall determine whether and how to reimburse for such costs. Any changes pursuant to this paragraph shall be subject to the minimum and maximum rates established pursuant to subsection (a).

Section 18. Determination of Maximum Allowable Capital Costs.

(a) The maximum capital basis per licensed bed shall be twenty-eight thousand five hundred dollars ($28,500.00) as of January 1, 1989.

(b) Increase in maximum capital basis. The maximum capital basis shall be increased effective July 1 of each year by the lesser of one-half (½) of the percentage increase in the Dodge Construction Index, an independently published index used to calculate construction costs, or one-half (½) of the increase in the consumer price index, the consumer price index for all Urban Consumer (CPI-U (United States city average)), as determined by the United States Department of Labor and Statistics. (If either the Dodge Construction Index or the consumer price index is discontinued, the Department shall use whichever index is available.) The increase shall be rounded to the nearest one hundred dollars ($100.00).

(c) Allowable maximum capital basis shall be limited to the maximum capital basis per licensed bed at the time of construction of each bed or January 1, 1989, whichever is later, plus one-half (½) of the difference between that amount and the maximum capital basis per bed at the rate effective date.

(d) For facilities constructed, acquired or leased prior to January 1, 1989, and facilities constructed after January 1, 1989, the capital component limitation shall be limited to the allowable maximum capital basis for each licensed bed times the average annual Federal Home Loan Mortgage Corporation, Whole Loan Purchase, Multi-Family rate rounded to the nearest half percent (.5%), divided by ninety (90) percent of a nursing facility's total available licensed beds, times three hundred and sixty-five (365) days. The average annual Federal Home Loan Mortgage Corporation Whole Loan Purchase, multi-family rate, shall be calculated as of January 1, 1989. This limit shall apply to all depreciation, interest, lease, rent, or other consideration paid for the use of property.

(e) For facilities acquired through purchase or a capital lease as defined by GAAP on or after January 1, 1989, the buyer/lessee's allowable historical cost of property shall be limited to the seller/lessor's acquisition cost increased by the lesser of one-half (½) of the percentage increase in the Dodge Construction Index, or one-half (½) of the increase in the consumer price index. (If either the Dodge Construction Index or the consumer price index is discontinued, the Department shall use whichever index is available.) The maximum capital basis buyer/lessee shall be limited to the seller/lessor's maximum capital basis at the date of transaction. Any additional allowable capital expenditures incurred by the buyer/lessee shall be treated in the same manner as if the seller/lessor had acquired the additional capital expenditure. For facilities leased through a lease determined not to be a capital lease in accordance with GAAP on or after January 1, 1989, the lessee's allowable capital component shall be limited to the lessor's capital component at the date of transaction. The maximum capital basis of the lessee shall be limited to the lessor's maximum capital basis at the date of transaction.

Section 19. Inflation Adjustment.

(a) A nursing facility's allowable operating and allowable health care costs shall be inflated from the midpoint of the cost reporting period to the midpoint of the rate period as defined in Section 13 of this Chapter.

(b) "Inflation factor." The inflation factor is the Skilled Nursing Facility (SNF) Market Basket as published quarterly by DRI/Global Resources or its successor.

Section 20. Incentive Adjustment.

(a) Eligibility for incentive adjustment. A nursing facility with allowable operating cost below the operating cost component limitations established pursuant to this Chapter shall be eligible for an incentive adjustment.

(b) Computation of incentive adjustment. The incentive adjustment shall be twenty-five (25) percent of the difference between the nursing facility's allowable operating cost and the operating cost component limitations. That amount shall be calculated on a per diem basis and added to the nursing facility's inflation adjusted operating costs. The adjustment may not exceed two dollars ($2.00) per day.

Section 21. Legislative Appropriations.

(a) If the Wyoming Legislature passes a special appropriation to be used to increase nursing facility reimbursement for any specific purpose defined by the Legislature in such appropriation, this section shall control the allocation of such appropriation among nursing facilities in Wyoming.

(b) The Department shall develop a methodology to allocate the appropriation among nursing facilities in Wyoming.

(i) The Department may consult with representatives of nursing homes, such as representatives of associations which represent nursing homes in Wyoming, about how to allocate the appropriation.

(ii) The Department shall collect the information it deems necessary to allocate the appropriation. The Department shall request information in writing, by certified mail, return receipt requested. Providers shall furnish the requested information in the format and according to the schedule established by the Department. All such information shall be submitted to the Department by certified mail, return receipt requested. Any information provided to the Department shall contain a certification statement substantially in the form specified in subsection 5(d) of this Chapter.

(iii) After collecting information pursuant to subsection (b)(i), the Department shall develop a methodology to distribute the appropriation among nursing facilities in Wyoming. The methodology shall:

(A) Effectuate the legislative purpose of the appropriation in a timely and cost-effective manner;

(B) Benefit Wyoming nursing facilities equitably, such that no nursing facility benefits disproportionately, based on the intent of the appropriation;

(C) Include safeguards to ensure that appropriated funds are spent for the purposes specified in the appropriation. Such safeguards shall include reporting and documentation requirements for facilities; and

(D) Specify how such funds shall be reported on facilities' future cost reports, and whether and how such funds shall be considered in determining facilities' future base rates and per diem rates.

(E) The Department shall disseminate the methodology to facilities through a manual or bulletin.

(c) Funds which are not spent for the purposes specified in the appropriation or pursuant to the methodology developed by the Department, and funds for which a nursing facility cannot provide documentation as required by the Department, are overpayments and shall be recovered pursuant to Section 31 of this Chapter.

(d) Any increase in a nursing facility's per diem rate or other payment pursuant to this Section shall be subject to the cost component limitations of Section 16 of this Chapter, and the maximum per diem rate established pursuant to Section 17 of this Chapter, except as otherwise specified in the methodology developed pursuant to subsection (b) of this Section.

Section 22. Reimbursement Rate for Extraordinary Care Clients.

(a) Medicaid reimbursement for services provided to an extraordinary care client may be negotiated for clients who require skilled nursing facility care and require special care or clinically complex care as recognized with prior authorization by the Department. Services for these clients shall be the per diem rate calculated in accordance with other sections of this Chapter, plus a negotiated rate to cover the cost of medically necessary services and supplies that are not included in the per diem rate.

(i) The Department will negotiate with providers on a case-by-case basis to determine the negotiated rate and the billing procedures for extraordinary care clients.

(ii) Prior to such negotiations, the provider shall submit to the Department:

(A) A treatment plan; and

(B) A proposed reimbursement rate, including all relevant financial records and all medical records which document the medical necessity for services provided to an extraordinary care client.

(iii) The Department may request, and the provider shall furnish before a negotiated rate is established, additional information to document the medical necessity for services provided to an extraordinary care client.

(iv) The negotiated rate shall be the rate determined by the Department based on the negotiations with the provider for medically necessary services.

(v) The Department shall reevaluate the condition of an extraordinary

care client after the first fifteen (15) days after admission, again at (30) days, ninety (90) days thereafter, and then every six (6) months thereafter. The State shall review records on a yearly basis to determine if a renegotiation of the negotiated rate is necessary to reflect changes in the client's condition. Exceptions to the frequency of reporting are at the discretion of the reviewer. It is the provider's responsibility to report any significant changes in care requirements, condition changes, and/or changes in client physical location at any time prior to the established review.

(b) All inclusive. The per diem rate plus the negotiated rate shall be an all inclusive reimbursement rate for all services and supplies furnished by the nursing facility, except as specified in Section 24 of this Chapter, and/or as otherwise agreed by the Department.

(c) Maximum rate. The negotiated rate shall not exceed the actual cost of the services provided to the extraordinary care client.

(d) Until the Department agrees, in writing, to a negotiated rate, reimbursement for services provided to an extraordinary care client shall be limited to the nursing facility's per diem rate.

(e) The nursing facility shall maintain records of the costs it incurs in furnishing services to each extraordinary care client. Costs related to services furnished to extraordinary care clients, other than nursing facility services, are not allowable costs for purposes of determining the nursing facility's per diem rate.

Section 23. Contracted Rate.

(a) The Department may pay a contracted rate to a nursing facility that furnishes added value. The contracted rate may exceed the nursing facility's per diem rate as determined pursuant to Section 17 of this Chapter.

(b) The Department shall negotiate and enter into contracts for added value using the following procedures:

(i) Determine what constitutes added value, taking into consideration for each nursing facility, the factors specified in (A) and the objectives specified in (B):

(A) Factors:

(I) The standard level of care, reasonably expected to be furnished in the nursing facility;

(II) The quality of care furnished in the nursing facility;

(B) Objectives:

(I) Reduction in the number and frequency of institutionally acquired infections;

(II) Reduction in the number and frequency of adverse resident incidents, such as falls, skin tears, and wandering from the facility.

(III) Reduction in official and unofficial complaints;

(IV) Maintenance of residents' ideal body weight;

(V) Maintenance or improvement of nursing facility survey results;

(VI) Maintenance of ambulatory levels of residents from admission to discharge;

(VII) Increases in the number of discharges to lesser acute settings; and

(VIII) Decreases in the incidence of residents' incontinence.

(ii) Solicit proposals for added value contracts; and

(iii) Negotiate with providers.

(c) The Department will negotiate with providers on an individual basis to determine whether a contracted rate is appropriate for that nursing facility, using value added criteria developed for that nursing facility.

(i) Prior to such negotiations, the provider shall submit to the Department, in the format prescribed by the Department:

(A) A proposed contracted rate; and

(B) Supporting documentation, including:

(I) All relevant financial records and medical records which demonstrate the added value the provider is or will be furnishing to clients;

(II) A proposed method of collecting and evaluating clinical data to demonstrate that added value is being furnished, such method to be subject to review and approval by the Department; and

(III) The additional cost the nursing facility will reasonably and necessarily be incurring to provide that added value.

(ii) The Department may request, and the provider shall furnish before a contracted rate is established, additional information to document the added value and/or added costs.

(iii) The contracted rate shall be the rate agreed upon by the provider and the Department for the value-added performance. The rate shall apply to all clients in the nursing facility, unless otherwise agreed by the Department.

(iv) The Department may establish monitoring criteria and procedures to determine whether the added value is being furnished.

(v) If the Department determines that the value added criteria are not being satisfied, the Department shall reduce the nursing facility's Medicaid reimbursement rate to the per diem rate established pursuant to Section 17 of this Chapter.

(d) All inclusive. The contracted rate shall be an all inclusive per diem rate for all services and supplies furnished by the nursing facility, except as specified in Section 24 of this Chapter, and/or as otherwise agreed by the Department.

(e) Maximum rate. The negotiated rate shall not exceed the nursing facility's actual costs.

(f) Until the Department agrees, in writing, to a contracted rate, reimbursement for services provided to clients shall be limited to the nursing facility's per diem rate as determined in Section 17 of this Chapter.

(g) The Department’s refusal to agree to a contracted rate requested by a provider is not an adverse action for purposes of the Rules and Regulations of Wyoming Medicaid, Chapter 2, State Licensed Shelter Care Eligibility Services.

Section 24. Nursing Care Facility Assessment Act.

(a) Nursing facility adjustment payments to providers based on the upper payment limit calculation.

(i) The Department will make adjustment payments to nursing facilities under the provisions of the Nursing Care Facility Assessment Act, W.S. §§ 42-8-101 through 109.

(A) Adjustment payments will be calculated prospectively on an annual basis to be effective from October 1 through September 30 of each year. The

adjustments will be paid quarterly. New providers opening during that assessment year will not be included in the program until the next assessment year.

(B) The quarterly adjustment payments will be due to the providers not later than thirty (30) days after the end of each calendar quarter.

(C) Change of ownership. If a facility changes ownership, beginning at the start of the calendar quarter following the date of the change of ownership, the new owner will collect the adjustment payment that was calculated using the prior owner's data.

(D) Adjustment payments will be calculated based on Medicaid days paid by the Wyoming medical assistance program.

(I) Wyoming Medicaid days will be collected for the dates of service represented in cost reports ended in the calendar year that precedes the assessment effective each October 1. The Medicaid days will be generated by the Department from their MMIS payment system.

(II) New facilities without a qualifying cost report. For new facilities that opened prior to the October 1 annual calculation that do not have either a full year cost report or a qualifying cost report, as described in Section 5(c) of this Chapter, resident days will be determined using more current information and will be annualized.

(b) Nursing facility assessment payable to the Department.

(i) The Department will collect an assessment from nursing facilities under the provisions of the Nursing Care Facility Assessment Act, W.S. §§ 42-8-101 through 109.

(A) Assessments will be calculated prospectively on an annual basis to be effective from October 1 through September 30 of each year. The annual assessments will be paid quarterly. New providers opening during that assessment year will not be included in the program until the next assessment year.

(B) The quarterly assessments will be due to the Department no later than forty-five (45) days after the end of each calendar quarter.

(C) Change of ownership. If a facility changes ownership, beginning with the quarter following the date of the change of ownership, the new owner will assume the payment schedule calculated using prior owner's data. If it is not clear to the Department which owner is responsible for the assessment, the owner who received the quarterly adjustment payment will be responsible to pay the Department for the assessment related to that same quarter.

(D) Assessments will be calculated based on a per-resident day basis, exclusive of Medicare resident days.

(I) Resident days will be collected from the Wyoming Nursing Home Reimbursement System, Financial Report for Nursing Homes (cost report) that ended in the calendar year that precedes the assessment effective each October 1. The Department will revise its cost report form to collect the appropriate patient day data. Until the revised cost report forms are in use and have been filed with the Department, the Department will utilize a provider survey to gather the necessary data.

(II) New facilities without a qualifying cost report. If a new facility opened prior to the October 1 annual calculation that does not have either a full year cost report or a qualifying cost report, as described in Section 5(c) of this Chapter, resident days will be determined using more current information and will be annualized.

(E) Assessment expenses shall be reported on the State of Wyoming Financial Report for Nursing Homes annual cost report. Expenses should be reported in the administrative and general section of the operating cost section. Additionally, these expenses should be reported on schedule D of this same cost report.

Section 25. Medicaid Allowable Payment for Medicaid Program Services. Any Medicaid program service other than nursing facility services reimbursable within this Chapter shall be reimbursed according to the rules and policies of the Department for that specific program.

Section 26. Billing Requirements.

(a) Submission of claims. A provider seeking Medicaid reimbursement for services provided to a client must submit claims on the forms and in the manner specified by the Department.

(b) Medicaid payment as payment in full. A provider which receives or requests Medicaid payment for services and supplies included in the per diem rate must accept Medicaid payment as payment in full for such services and supplies. A provider may not attempt to collect or retain payment in addition to the per diem rate, except as permitted by 42 C.F.R. § 483.10(c) or other applicable federal law.

Section 27. Change in Provider Status.

(a) Termination of participation. If a provider's participation in the Medicaid program is terminated or suspended for any reason, the provider must submit a cost

report for the period ending with the effective date of the termination or suspension. The cost report is due within forty-five (45) days after the date of termination or suspension, even though the provider's tax period does not end on the date of termination or suspension. The final month's payment due a provider shall be withheld until its cost report is filed and the Department has a reasonable time to perform a desk review and field audit of the cost report and patient funds account.

(b) Change of ownership.

(i) Notice of change of ownership. The parties to a transaction involving a change of ownership must notify the Department, in writing, of the proposed transaction no later than thirty (30) days before the effective date of the change.

(ii) Representation agreement. Upon a change of ownership, all parties to the transaction shall have thirty (30) days after the change to complete and sign a representation statement, in written form specified by the Department, which details the persons or entities which have assumed the assets and liabilities of a nursing facility. If a representation statement is not timely submitted, both the original provider and any subsequent provider shall be jointly and severally responsible for all Medicaid liabilities which exist either before or after the change of ownership.

Section 28. Reimbursement of Out-of-State Providers.

(a) The reimbursement rate for out-of-state facilities providing services to Wyoming clients shall be the lesser of:

(i) The Medicaid reimbursement rate the nursing facility receives for the same or similar services from the Medicaid program in the state where the nursing facility is located;

(ii) The average bed-weighted Medicaid rate in effect in Wyoming as of the previous July 1; or

(iii) The nursing facility's usual and customary rate.

(b) The average bed-weighted Medicaid rate in effect shall be determined by:

(i) Multiplying the number of licensed beds in each nursing facility by the Medicaid per diem rate in effect for that nursing facility;

(ii) Adding the products determined pursuant to (A); and

(iii) Dividing the sum determined pursuant to (B) by the total number of licensed beds in the state.

(c) No cost reports. An out-of-state provider need not submit cost reports to the Department.

(d) Billing requirements. An out-of-state provider must submit with each claim a certification of the provider's reimbursement rate under the Medicaid program in the state where the provider is located and the nursing facility's usual and customary charge.

Section 29. Record Retention.

(a) Providers shall comply with the Provider Records requirements of the Rules and Regulations of Wyoming Medicaid, Chapter 3, Provider Participation.

(b) Explanation of records. In the event of a field audit, the provider shall have available at the field audit location one (1) or more knowledgeable persons who can explain the provider's financial records, the accounting and control system and cost report preparation, including attachments and allocations, to the auditors.

(c) Failure to maintain records. A provider unable to satisfy any of the requirements of this Section shall be given a written notice of deficiency and shall have sixty (60) days after the date of the written notice to correct such deficiency. If, at the end of the sixty (60) days, the Department determines that the deficiency has not been corrected, the Department shall withhold twenty-five (25) percent of the provider's per diem rate for services provided on or after the sixtieth (60^{th}) day. If, at the end of one hundred and twenty (120) days after the mailing of the written notice of deficiency, the Department determines that the deficiency has not been corrected, the Department shall suspend all Medicaid payments for services provided after such date. Reimbursement shall not be reinstated until the Department determines that adequate records are being maintained. After the deficiency is corrected, the Department shall release any withheld payments.

(d) Out-of-state records. If a provider maintains financial or medical records out of state, the provider shall either transfer the records to an in-state location that is suitable for the Department to perform the field audit or reimburse the Department for reasonable costs, including travel, lodging and meals, incurred in performing the field audit in an out-of-state location.

Section 30. Repayment of Credit Balance.

(a) Report on cost report. A provider shall report a credit balance on the provider's cost report. A credit balance shall be repaid pursuant to subsection (c).

(b) Annual request. The Department may request the repayment of any credit balance annually. Such request shall be made in writing and mailed by certified mail, return receipt requested. The provider shall repay the credit balance within sixty (60)

days after the date of receipt of the request for repayment.

(c) A provider shall repay any credit balance within sixty (60) days after the date such credit balance is identified by the Department or the provider.

(d) Lump sum adjustment. If a credit balance identified pursuant to subsections (a) or (b) is not timely paid to the Department, the Department may recover the credit balance pursuant to Section 31 of this Chapter.

Section 31. Audits.

(a) Field audits. The Department or CMS may perform a field audit of a provider at any time to determine the accuracy and reasonableness of cost reports submitted by the provider and/or the validity of rate adjustments made pursuant to a desk review.

(b) Desk review. The Department or CMS may perform a desk review of a provider at any time to determine the accuracy and reasonableness of cost reports submitted by the provider.

(c) The Department or CMS may perform field audits or desk reviews through employees, agents, or through a third party. Audits shall be performed in accordance with GAAS.

(d) Disallowances.

(i) Nonallowable costs. If a field audit or desk review discloses nonallowable costs or costs for services and supplies not included in the per diem rate, the Department shall adjust the per diem rate retroactively to the beginning of the rate period in question, recover any overpayments pursuant to Section 31 of this Chapter, and adjust the per diem rate for the remainder of the rate period.

(A) Costs which are not reasonably related to services included in the Medicaid per diem rate, or which are against public policy, contractual allowances, courtesy discounts, charity allowances, and similar adjustments or allowances are adjustments to revenue and, therefore, are not included in allowable cost. Nonallowable costs also include, but are not limited to:

(I) Advertising expense (other than help wanted ads and telephone directory expense);

(II) Attorney fees and other costs associated with negotiations, administrative proceedings or litigation involving the Department, except as specified in settlement;

(III) Bad debts;

(IV) Cost arising from joint use of resources (including central office and pooled cost) not reasonably related to patient care;

(V) Capital costs due solely to changes in ownership;

(VI) Costs incurred in transactions with organizations related to the provider by common ownership or control, to the extent that such costs exceed the limits established under 42 C.F.R. § 413.17;

(VII) Costs incurred as a result of enforcement actions taken by the Department pursuant to the Rules and Regulations for Wyoming Medicaid, Chapter 5, Long Term Care Facility Remedies, Terminations, and/or CMS in response to nursing facility deficiencies, including costs of directed in-service training, suspended or denied per diem payments, reimbursement expenses, transfer costs, and costs relating to state monitoring and/or the appointment of a temporary manager;

(VIII) Costs not reasonably related to patient care;

(IX) The costs associated with ancillary and other services attributable to Medicare Part A or Medicare Part B, including direct and indirect costs;

(1.) Ninety (90) percent of the costs identified pursuant to this paragraph shall be nonallowable costs, and one hundred (100) percent of Medicare bed days shall be removed.

(2.) When determining the capital component for nursing facilities with occupancy below ninety (90) percent Medicare days will be computed to reflect Medicare occupancy.

(X) Costs related to the acquisition, establishment or operation of an in-house pharmacy, other than the reasonable costs of a pharmacy consultant;

(XI) Costs related to extraordinary clients that exceed the per diem rate;

(XII) Costs related to hospice services;

(XIII) Costs (such as legal fees, accounting and administration costs, travel costs, and the costs of feasibility studies) which are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition or merger for which any Medicaid payment has been previously made;

(XIV) Federal income and excess profit taxes;

(XV) Fees paid to directors and salaries, wages or fees paid to non-working officers, employees or consultants;

(XVI) Fund-raising expenses;

(XVII) Interest or penalties on federal or state taxes;

(XVIII) Judgments entered against a nursing facility or settlements entered into by a nursing facility arising out of actions or inactions of the nursing facility's agents or employees, including judgments entered against a nursing facility's agent or employee that a nursing facility pays, or settlements involving the nursing facility's agent or employee that the nursing facility pays;

(XIX) Life insurance premiums for officers and owners and related parties, except the amount relating to a bona fide nondiscriminatory employee benefits plan;

(XX) Meals and lodging provided to guests and employees. If the cost cannot be ascertained, the revenue from meals and lodging furnished to guests and employees shall be offset against the appropriate cost;

(XXI) Prescription drugs;

(XXII) Public relations expenses;

(XXIII) Resident personal purchases;

(XXIV) Return on equity;

(XXV) Self-employment taxes;

(XXVI) Stockholder relations or stock proxy expenses;

(XXVII)Taxes or assessments

(XXVIII) Telephone, television and radio which are located in patient accommodations and which are furnished solely for the personal comfort of patients;

(XXIX) Value of services (imputed or actual) rendered by non-paid workers or volunteers; and

(XXX) Vending machines and related supplies.

(ii) Unsubstantiated cost.

(A) Upon written request by the Department, a provider must substantiate cost or other information reported on the provider's cost report. Substantiation must be provided, in writing, within thirty (30) days after the date of the request.

(B) Any cost which a provider cannot substantiate shall be disallowed.

(C) Substantiation may include, but is not limited to, home office cost statement, resident census, statistical and related information, cost allocations, account analyses, invoices, stock ownership information, related parties' financial information, or subcontractor's financial information.

(e) Financial or medical records which are not made available at the time of an audit shall not be admissible at an administrative hearing held pursuant to Section 32 of this Chapter unless the nursing facility shows good cause for not making the records available at the time of the audit.

Section 32. Recovery of Overpayments. The Department may recover overpayments pursuant to the provisions of the Rules and Regulations of Wyoming Medicaid, Chapter 16, Medicaid Program Integrity.

Section 33. Reconsideration.

(a) A provider may request reconsideration of the decision to recover overpayments pursuant to the provisions of the Rules and Regulations of Wyoming Medicaid, Chapter 16, Medicaid Program Integrity.

(b) A provider may request reconsideration of the determination of the provider’s per diem rate following the procedures outlined in the Rules and Regulations of Wyoming Medicaid, Chapter 16, Medicaid Program Integrity.

Section 34. Disposition of Recovered Funds. The Department shall dispose of recovered funds pursuant to the provisions of the Rules and Regulations of Wyoming Medicaid, Chapter 16, Medicaid Program Integrity.

Section 35. Delegation of Duties. The Department may delegate any of its duties under this rule to the Wyoming Attorney General, HHS, any other agency of the Federal, State or local government, or a private entity which is capable of performing such functions, provided that the Department shall retain the authority to impose sanctions, recover overpayments or take any other final action authorized by this Chapter.

Section 36. 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 37. Superseding Effect. When promulgated, this Chapter supersedes all prior rules or policy statements issued by the Department, including manuals or bulletins, which are inconsistent with this Chapter.

Section 38. Severability. If any portion of these rules is found invalid or unenforceable, the remainder shall continue in effect.

ABD Pads
Adhesive Tape
Aerosol, other types
Air Mattresses, Air P.R. Mattresses
Airway-Oral
Alcohol Plaster
Alcohol Sponges
Alternating Pressure Pads
Applicators, Cotton-tipped
Applicators, Swab-eez
Aquamatice K Pads (Water-heated Pad)
Arm slings
Asepto Syringes
Baby Powder
Bandages
Bandages, Elastic or Cohesive
Band-Aids
Basins
Bed Frame Equipment (for certain immobilized bed patients)
Bed Rails
Bedpans, all types
Beds: Manual, Electric and Clinitron
Bedside Tissues
Bibs
Blood Infusion Sets
Bottle, Specimen
Canes, all types
Cannual, Nasal
Catheter Indwelling
Catheter Plugs
Catheter Tray
Catheter (any size)
Colostomy Bags
Combs
Commodes, all types
Composite Pads
Cotton Balls
Crutches, all types
Decubitus Ulcer Pads/Dressings
Denture Cleaner/Soak
Denture Cups
Deodorants
Diapers
Disposal Under pads

Donuts
Douche Bags
Drain Tubing
Drainage Bags
Drainage Sets
Drainage Tubes
Dressing Tray
Dressing, all types
Enema Soap
Enema Supplies
Enema Unit
Equipment and Supplies for Diabetic Blood and Urine Testing
Eye Pads
Feeding Tubes
Fingernail Clipping and Cleaning
Flotation Mattress or Biowave Mattress
Flotation Pads and/or Turning Frames
Foot Cradle, all types
Gastric Feeding Unit, including bags
Gauze Sponges
Gloves, Unsterile and Sterile
Gowns, Hospital
Green Soap
Hair Brushes
Hair Care, Basic
Hand Feeding
Heat Cradle
Heating Pads
Heel Protector
Hot Pack Machine
Hydraulic Patient Lifts
Hypothermia Blanket
Ice Bags
Incontinency Care
Incontinency Pads and Pants
Influenza Vaccine
Infusion Arm Boards
Infusion Pumps, Enteral and Parenteral
Inhalation Therapy Supplies
Irrigation Bulbs
Irrigation Trays
I.V. Needles
I.V. Trays
Jelly, Lubricating
Lines, Extra
Lotion, Soap and Oil

Massages (by nursing facility personnel)
Mattresses, all types
Medical Social Services
Medicine Dropper
Medicine Cups
Nasal Catheter
Nasal Catheter, Insertion and Tube
Nasal Gastric Tubes
Nasal Tube Feeding and Feeding Bags
Nebulizer and Replacement Kit
Needles (various sizes)
Needles: Hypodermic, Scalp and Vein
Nursing Services (all) regardless of level, including the administration of oxygen and restorative nursing care
Nursing Supplies and Dressing
Ostomy Supplies: Adhesive, Applicance, Belts, Face Plates, Flanges, Gaskets, Irrigation Sets, Night Drains, Protective Dressings, Skin Barriers, Tail Closures
Overhead Trapeze Equipment
Over the counter (OTC) drugs, as designated by the Food and Drug Administration
Oxygen, Gaseous and Liquid
Oxygen Concentrators
Oxygen Delivery Systems, Portable or Stationary
Oxygen Mask
Pads
Pitcher
Plastic Bib
Pump, Aspiration and Suction
Pumps for Alternating Pressure Pads
Respiratory Equipment: Ambu Bags, Cannulas, Compressors, Humidifiers, IPPS Machines and Circuits, Mouthpieces, Nebulizers, Suction Catheters, Suction Pumps, Tubing, etc.
Restraints
Room and Board (semi-private or private if necessitated by a medical or social condition)
Sand Bags
Scalpel
Shampoo
Shaves
Shaving Cream
Shaving Razors
Sheepskin
Side Rails
Soap
Special Diets
Specimen Cups
Sponges
Steam Vaporizers

Sterile Pads
Sterile Saline for Irrigation
Sterile Water for Irrigation
Stomach Tubes
Suction Catheter
Suction Machines
Suction Tube
Surgical Dressings (including sterile sponges)
Surgical Pads
Surgical Tapes
Suture Removal Kit
Suture Trays
Syringes, all sizes
Syringes, Disposable
Tape, (for laboratory tests)
Tape, Non-allergic or Butterfly
Testing Sets and Refills (S & A)
Therapy Services, including specialized rehabilitative services as set forth in 42 C.F.R. §483.45
Toenail Clipping and Cleaning
Tongue Depressors
Toothbrushes
Toothpaste
Tracheostomy Sponges
Trapeze Bars
Tray Service
Under pads
Urinals, male and female
Urinary Drainage Tube
Urinary Tube and Bottle
Urological Solutions
Walkers, all types
Water Circulating Pads
Water Pitchers
Wheelchairs: Amputee, Geriatric, Heavy Duty, Hemi, Lightweight, One Arm Drive, Reclining, Rollabout, Semi-Reclining, Standard

WYOMING MEDICAID RULES

CHAPTER 17

NURSING FACILITY RESIDENT TRUST ACCOUNTS

Section 1. Authority. This rule is promulgated by the Department of Health pursuant to the Medical Assistance and Services Act at W.S. § 42-4-101, et seq., and the Wyoming Administrative Procedure Act at W.S. § 16-3-101, et seq.

Section 2. Purpose and Applicability.

(a) This Chapter has been adopted to establish the standards and procedures for all resident trust accounts maintained by nursing facilities.

(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.

(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 3. Definitions. Except as otherwise specified in the Rules and Regulations of Wyoming Medicaid, Chapter 1, Definitions, the terminology used in this Chapter is the standard terminology and has the standard meaning used in healthcare, Medicaid, and Medicare.

Section 4. Notice to Residents. Notice of covered services. At the time of admission, the nursing facility shall provide the resident and the resident's representative with a written notice that contains the information specified in subsections (a) through (g). Such notice shall also be given at least once every year after admission, and within sixty (60) days after there is any change in the services available to residents, the charges for such services or the services included in the Medicaid reimbursement rate. The notice shall contain:

(a) An itemized statement of the services provided by the nursing facility as part of the nursing facility's Medicaid reimbursement rate;

(b) An itemized statement of the services provided by the nursing facility that are not covered by the nursing facility's Medicaid reimbursement rate or Medicare and that may be charged to the resident, including the charge for each such service;

(c) A statement that the client is not required to deposit personal funds in a resident trust account.

(i) Personal funds account. For purposes of this Chapter, personal funds are all funds which belong to a resident, from whatever source, including the resident's personal care allowance.

(ii) Resident trust account. For purposes of this Chapter, the resident trust account is an account maintained by a facility in which a facility resident's personal funds are deposited and held in trust by the facility for the use and benefit of the resident.

(d) A description of the resident's right to select one (1) of the following alternatives for the management of personal funds:

(i) The resident may receive, retain and manage personal funds directly or through a legal guardian;

(ii) The resident may apply to the Social Security Administration for the designation of a representative payee to receive and manage personal funds; or

(iii) The resident may designate, in writing, another person to receive and manage personal funds.

(e) A statement that any charge for the nursing facility managing the resident's trust account is included in the Medicaid reimbursement rate;

(f) A statement that the resident is entitled to one (1) accounting per calendar month of the resident's trust account upon the written request of the resident, the resident's legal guardian, the resident's representative payee or such other person as has been designated to manage the resident's trust account;

(g) A statement that if the resident is or becomes incapable of managing personal funds and has not designated another person to do so, the nursing facility shall arrange for the management of the resident's personal funds pursuant to the provisions of this Chapter; and

(h) Notice of potential ineligibility for Medicaid or SSI. In addition to the notice described above, the nursing facility shall notify a client when the balance of the resident's trust account is within two hundred dollars ($200.00) of the amount determined under 42 U.S.C 1382(a)(3)(B). The notice shall be in writing and shall inform the client that if the amount in the account plus the client's other nonexempt resources reaches the amount determined under 42 U.S.C. 1382(a)(3)(B), the client may lose eligibility for Medicaid, SSI or both.

Section 5. Charges to Residents.

(a) No charges for services included in per diem rate or covered by Medicare.

A nursing facility may charge a resident only for services which are not included in the nursing facility's per diem rate for that resident and which are not covered by Medicare.

(b) Charges to personal care allowance. A nursing facility may seek reimbursement from a resident's personal care allowance only for services directly related to the resident's personal needs, including, but not limited to:

(i) Commissary items, such as books, magazines and candy; or

(ii) Premiums on life insurance policies or burial expense policies.

Section 6. Nursing Facility's Fiduciary Responsibilities.

(a) Upon written authorization from the resident, or any individual designated pursuant to Section ~~4~~ of this Chapter, the nursing facility shall accept responsibility for:

(i) Receiving personal funds;

(ii) Depositing personal funds in the resident's trust account;

(iii) Safeguarding the resident's personal funds; and

(iv) Managing the resident's trust account, including accounting for all personal funds received by the nursing facility.

(b) Management. The nursing facility may perform the duties specified in this Chapter directly or through a bank, which is a federally or state chartered bank, savings and loan or credit union which is insured by an agency of the United States Government. The delegation of such duties to a bank shall not affect the nursing facility's ultimate responsibility for ensuring that the requirements of this Chapter are met.

(c) Interest. The nursing facility may deposit personal funds in a non-interest bearing account if such funds do not exceed fifty dollars ($50.00). Funds in excess of fifty dollars ($50.00) shall be transferred to an interest bearing account within fifteen (15) days after the date a client's trust account exceeds fifty dollars ($50.00). All such interest shall accrue to the resident's trust account.

(d) Pooled funds. Resident trust accounts may be pooled. If the nursing facility uses a pooled account, it must:

(i) Maintain records adequate to clearly disclose the amount of each resident's trust account and each transaction involving such account;

(ii) Indicate on the account that the nursing facility does not have an ownership interest in the funds; and

(iii) Establish a written policy for the attribution of accrued interest among the pooled accounts. Interest may be prorated by:

(A) End of quarter balance;

(B) End of month balance;

(C) Daily balance; or

(D) Average daily balance.

(e) Record keeping requirements. The nursing facility shall maintain current, written records of each transaction involving each resident's trust account for which the nursing facility is responsible. The records shall include:

(i) The resident's name;

(ii) The name of the resident's representative;

(iii) The date of the resident's admission;

(iv) The date and amount of each deposit and withdrawal, the name of the person who accepted the withdrawn funds, the purpose for which funds were withdrawn, and the balance after each transaction;

(v) Receipts indicating the expenditure of the funds;

(vi) All accrued interest; and

(vii) If applicable, the date of discharge, the date the resident's trust account was closed and final disposition of the resident's trust account.

(f) Resident unable to manage funds. When a resident is not capable of managing personal funds for any reason, the nursing facility shall, in addition to the record-keeping required by subsection (e), maintain prenumbered voucher slips which:

(i) Indicate the item(s) purchased with the resident's personal funds; and

(ii) Contain two (2) signatures for each withdrawal, one (1) of which shall be that of a supervisory employee of the nursing facility. If the withdrawal is to reimburse another person for the expenditure of funds on behalf of the resident, that person's signature shall appear on the voucher.

(g) Quarterly reports. Within thirty (30) days after the end of each calendar

quarter, the nursing facility shall issue a written accounting to each resident or resident representative for whom the facility maintains a resident trust account. The written accounting shall include:

(i) The balance at the beginning of the quarter;

(ii) Total deposits and withdrawals;

(iii) Interest earned;

(iv) The balance at the end of the quarter; and

(v) The location of the resident's trust account and the account's identification number.

(h) Access to resident trust accounts. The nursing facility shall provide access to resident trust accounts:

(i) For at least two (2) hours during normal business hours each working day; and

(ii) For a reasonable time on Saturdays and Sundays.

(i) Commingling of resident trust accounts. The nursing facility shall not commingle resident trust accounts with any of the nursing facility's funds. Each resident trust account shall state that the nursing facility has no ownership rights in the account and that the funds are held in trust.

(j) Return of personal funds. The nursing facility shall, upon written request by a resident or the person designated pursuant to subsection 4(d) of this Chapter:

(i) Return the balance of the resident's trust account to the requesting party within five (5) days after receipt of such request; and

(ii) Provide a written accounting, including all transactions from the date of the last quarterly report.

(k) Death of resident. Upon the death of a resident for whom the nursing facility is maintaining a resident trust account, the nursing facility shall:

(i) Provide the personal representative of the estate of the resident, or any other person entitled to distribution pursuant to W.S. § 2-4-101, *et seq*., with a full, written accounting of the resident's trust account within thirty (30) days after the date of the resident's death; or

(ii) If there is no person entitled to an accounting pursuant to paragraph (i), provide a full, written accounting of the resident's trust account to the person designated pursuant to subsection 4(d) of this Chapter or the resident's representative.

(iii) If the funds in a deceased resident's trust account are not claimed within six (6) months after the resident's death, the funds shall be handled according to the Wyoming Probate Code.

(l) Change of ownership. A nursing facility shall, within sixty (60) days before a change of ownership:

(i) Provide a written accounting of all resident trust accounts to the new owner; and

(ii) Provide a written accounting to each resident or resident representative of all transactions from the date of the last quarterly report and the balance in the account on the date of the accounting.

(iii) On or before the effective date of the change of ownership, the nursing facility shall surrender all resident trust accounts to the new ownership, obtain a written receipt for such funds, and otherwise comply with the provisions of the Rules and Regulations of Wyoming Medicaid, Chapter 7, Nursing Home Reimbursement System.

(iv) Failure to comply with the provisions of this subsection shall result in the nursing facility transferring ownership and the new ownership remaining jointly liable for all resident trust accounts entrusted to the nursing facility at or before the time of the change of ownership.

(m) Accounting principles. All accountings required by this Chapter shall be performed in accordance with generally accepted accounting principles (GAAP).

Section 7. Audits of Resident Trust Accounts.

(a) Audits are subject to the requirements of the Rules and Regulations of Wyoming Medicaid, Chapter 16, Medicaid Program Integrity.

(b) Repayment of missing funds. The nursing facility shall, within ten (10) days after receipt of notice of missing funds, replace such funds and provide a written accounting of such replacement to the Department, even if the nursing facility has requested reconsideration or requested an administrative hearing regarding the determination of missing funds. Missing funds are personal funds for which a facility is responsible, which are determined after an audit to be missing or otherwise unaccounted for. If the nursing facility does not replace the missing funds, the Department may recover such funds from the facility subject to the requirements of the Rules and

Regulations of Wyoming Medicaid, Chapter 16, Medicaid Program Integrity.

Section 8. Delegation of Duties. The Department may delegate any of its duties under this rule to the Wyoming Attorney General, HHS, any other agency of the Federal, State or local government, or a private entity which is capable of performing such functions, provided that the Department shall retain the authority to impose sanctions, recover overpayments or take any other final action authorized by this Chapter.

Section 9. 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 10. Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Department, including manuals and/or bulletins, which are inconsistent with this Chapter.

Section 11. Severability. If any portion of these rules is found invalid or unenforceable, the remainder shall continue in effect.

WYOMING MEDICAID RULES

CHAPTER 19

NURSING FACILITY PREADMISSION SCREENINGS

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

Section 2. Purpose and Applicability.

(a) This Chapter establishes methods and standards for preadmission screening of clients and prospective clients of nursing facilities. The requirements of this Chapter apply to all clients and prospective clients, regardless of payment source.

(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.

(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 3. Definitions. Except as otherwise specified in the Rules and Regulations of Wyoming Medicaid, Chapter 1, Definitions, the terminology used in this Chapter is the standard terminology and has the standard meaning used in healthcare, Medicaid, and Medicare.

Section 4. General Provisions. This rule is intended to be read in conjunction with the Rules and Regulations of Wyoming Medicaid, Chapter 22, Nursing Facility Long Term Care/Home/Community Based Evaluation, and 42 C.F.R., Ch. IV, Subch. G, Pt.483, Subpt. C.

Section 5. Admission of Persons Diagnosed as Mentally Ill or with an Intellectual Disability or Related Condition.

(a) Mentally ill individuals. Except as otherwise provided by this Section, a nursing facility shall not admit any mentally ill individual unless:

(i) Prior to admission, the state mental health authority (SMHA) has determined, based on a physical and mental evaluation performed by a person or entity other than the state mental health authority, that the individual requires nursing facility services because of his or her physical and mental condition; and

(ii) If the individual requires nursing facility services, the SMHA has also determined whether the individual requires specialized services.

(b) Individuals or persons with an intellectual disability or related conditions. Except as otherwise provided by this Section, a facility shall not admit any individual with an intellectual disability or related condition unless:

(i) Prior to admission, the state intellectual disability authority (SIDA) has determined, based on a physical and mental evaluation performed by a person or entity other than the SIDA, that the individual requires nursing facility services because of his or her physical and mental condition; and

(ii) If the individual requires nursing facility services, the SIDA has also determined whether the individual requires specialized services.

(c) Penalty for admission prior to screening. Any facility that admits any mentally ill individual or any individual with an intellectual disability or related condition prior to a determination of appropriate placement shall be subject to:

(i) Denial of Medicaid payment for a Medicaid-eligible individual; and

(ii) Regardless of the individual's payment source, the Department may impose any of the remedies specified in Chapter 5, using the procedures specified in Chapter 5.

Section 6. Level I Screening.

(a) Purpose. The Level I screening is performed by qualified staff of a nursing facility or hospital to determine whether an individual seeking admission to or residing in a facility needs further evaluation because of suspected mental illness, an intellectual disability or a related condition.

(b) Applicability. All individuals, regardless of payment source, who apply for admission to a facility on or after January 1, 1989, or who were clients in a facility on January 1, 1989, are subject to the requirements of this Section.

(c) Frequency of screening.

(i) Any individual who was a client in a facility before January 1, 1989, must be screened on or before April 1, 1990.

(ii) Any individual seeking admission to a facility as a new admission on or after January 1, 1989, must be screened before admission.

(iii) If the screening does not result in a referral to Level II, the individual need not be screened again unless there is a significant change in the individual's condition that indicates that a Level II screening is advisable.

(d) Screening. All screening shall be performed by a qualified staff member of the facility. A qualified staff member is a member of a nursing facility's or hospital's staff that is qualified, by education, professional status or administrative authority, to discern the possibility or probability of mental illness, intellectual disability, or related condition by reviewing medical records, observation of presenting evidence, or other sources. The screener uses the following criteria:

(i) Mental illness. The screener shall consider whether:

(A) The individual is diagnosed with a serious mental illness, as defined by 42 C.F.R. § 483.102. This diagnosis shall not include individuals experiencing temporary anxiety or depressive reactions to a terminal or chronic debilitating condition for which specialized services would not be appropriate, but for which mental health services of a lesser intensity than specialized services may be required based on evaluation and recommendation by a physician or a qualified mental health professional;

(B) The individual has a history of mental illness requiring treatment more intensive than out treatment; or

(C) There is presenting evidence of a serious mental illness, including possible disturbances in orientation, affect or mood that is not attributable to dementia or other medical diagnosis or treatment.

(ii) Intellectual Disability. The screener shall consider whether:

(A) A physician or qualified intellectual disability professional has given the individual a primary or secondary diagnosis of mental retardation or related condition;

(B) The individual has a history of an intellectual disability or related condition;

(C) There are cognition or behavior deficits indicating an intellectual disability or related condition; or

(D) The individual was referred by an agency that serves persons with an intellectual disability or related condition, and the individual was eligible for that agency's services.

(e) Recommendation. Upon completion of the Level I screening, the screener

shall make a recommendation as to whether the individual should be referred for a Level II screening:

(i) If the recommendation is that a Level II screening is not necessary, the individual may be admitted to the facility; or

(ii) If the recommendation is that a Level II screening is necessary, the provisions of Section 7 of this Chapter apply.

(f) Notice. The nursing facility must provide written notice to the individual or client, or his or her legal representative, if the individual is suspected of having mental illness, an intellectual disability or related condition, and is being referred to the SMHA or SIDA for Level II screening. This notice is required for first time Level II identifications only.

(g) Documentation requirements. The facility shall complete documentation in the format specified by the Department.

Section 7. Level II Screening.

(a) Purpose. To determine whether an individual with a mental illness has an intellectual disability or related condition which requires, because of the individual's physical and mental condition, the level of services provided by a nursing facility and whether the individual requires specialized services.

(b) Applicability. All individuals who apply for admission to a facility on or after January 1, 1989, or who were clients in a facility on January 1, 1989, are subject to the requirements of this Section if the Level I screening indicates the possibility of mental illness, intellectual disability or related condition. No facility shall admit any individual for whom the Level I screening indicates a reason to refer the individual for a Level II screening until the Level II screening is completed and a determination of appropriate placement rendered.

(c) Change in condition. If there has been a previous Level II and the resident has a change in physical or mental functioning, a new Level II must be requested promptly by the nursing facility. This will be done by completing a new Level I form and submitting it through established procedures. The facility must indicate on the Level I form that a new Level II is being requested because a significant change in the person's physical or mental functioning.

(d) Failure to timely comply with Professional Activities Survey (PAS) requirements.

(i) PAS. Medicaid reimbursement shall be disallowed for nursing facility services furnished to a client before the Level II screening is completed and a

determination of appropriate placement in a nursing facility is made.

(ii) Non-Medicaid individuals. For failure to timely comply with PAS requirements for non-Medicaid eligible individuals, the Department may impose any of the remedies specified in the Rules and Regulations of Wyoming Medicaid, Chapter 5, Long Term Care Facility Remedies, Terminations, using the procedures specified in Chapter 5.

(e) Categorical determinations. A categorical determination takes into account that certain diagnoses, levels of severity of illness, or need for a particular service clearly indicate that admission to or residence in a nursing facility are appropriate without the need for a Level II review and determination. An individual with mental illness, an intellectual disability or related condition who meets the criteria for any category in this section shall be deemed appropriate for nursing home placement.

(i) Terminal illness. A diagnosis of terminal illness constitutes a Level II determination of appropriate placement, and specialized services not required.

(ii) Severe medical condition. A diagnosis of severe medical condition constitutes a Level II determination of appropriate placement. The individual must meet the following condition: An individual is mentally ill, has an intellectual disability or related condition meets the criteria for "severe medical condition" if he or she is comatose, ventilator dependent, or functioning at the brain stem level, or has been diagnosed by a physician as having chronic obstructive pulmonary disease, severe Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, congestive heart failure, severe cardiovascular accident (CVA), quadriplegia, advanced multiple sclerosis, end stage renal disease, severe diabetic neuropathy, or refractory anemia. The illness must result in a level of impairment so severe that the individual could not be expected to benefit from specialized services for mental illness, intellectual disability or related condition.

(iii) Convalescent care. The individual that is mentally ill has an intellectual disability or related condition and requires a medically prescribed nursing facility stay of no more than one hundred twenty (120) days. After that time, the facility must refer the individual for a Level II. The individual is mentally ill, has an intellectual disability or related condition and has an acute physical illness which:

(A) Required hospitalization; and

(B) Does not meet the criteria for an exempt hospital discharge as defined in 42 C.F.R. § 483.106.

(iv) Provisional placement. The individual requires a nursing facility stay of no more than fourteen (14) days. After that time, the facility must refer the individual for a Level II. The individual is mentally ill, intellectually disabled or related

condition and requires admission for:

(A) Delirium, where an accurate diagnosis cannot be made until the delirium clears; or

(B) Respite care.

(v) Emergency admissions. The individual is mentally ill, intellectually disabled or a related condition and requires a nursing facility stay of no more than seven (7) days for his or her protection. After that time, the facility must refer the individual for a Level II.

(f) Criteria for Level II screening.

(i) Determination of medical necessity. Each client referred for a Level II screening, regardless of payment source, must be evaluated for medical necessity pursuant to Chapter 22.

(ii) Level II screening shall be performed using the minimum criteria specified by CMS in §§ 4251 through 4253 of the State Medicaid Manual (SMM), as appropriate for a specific individual. The SMM is published by CMS and is available from CMS or the Department.

(iii) Determination of appropriate placement. The SMHA or SIDA (as applicable) shall review the mental and physical evaluations and the determinations of medical necessity and determine whether, based on the individual's physical and mental condition, the individual requires the level of services provided by the nursing facility (NF) into which the individual seeks admission.

(iv) Determination of need for specialized services.

(A) Mentally ill persons. The need for specialized services for mentally ill persons shall be determined using the procedures and protocols of the SMHA. The procedures and protocols of the SMHA are available from the SMHA or the Department.

(B) Persons with an intellectual disability. The need for specialized services for persons with an intellectual disability shall be determined using the procedures and protocols of the SIDA. The procedures and protocols are available from SIDA or the Department.

(g) Results of Level II screening. The Level II screening will result in a determination of the appropriateness of nursing facility placement and the need for specialized services. The following outcomes are possible:

(i) Individual requires nursing facility services~~,~~ but does not require specialized services.

(A) Nursing facility placement is appropriate; and

(B) Mental health services of a lesser intensity than specialized services may be recommended.

(ii) Individual requires nursing facility services and specialized services provided in the nursing facility.

(A) Nursing facility placement is appropriate;

(B) The State must arrange for provision of specialized services; and

(C) Persons who do not require nursing facility services but require specialized services and choose to remain in the nursing facility under the thirty (30)-month rule are deemed to require nursing facility services.

(iii) Individual does not require nursing facility services or specialized services.

(A) Nursing facility placement is not appropriate or authorized, admission is denied; or

(B) If the client is already admitted, nursing facility must arrange for orderly discharge, including preparation and orientation of for discharge.

(iv) Individual does not require nursing facility services but does require specialized services that cannot be provided in the facility.

(A) Nursing facility placement is not appropriate or authorized, admission is denied; or

(B) If the client is already admitted, facility must arrange for orderly discharge, including preparation and orientation of for discharge.

(v) No evidence of serious mental illness and no evidence of an intellectual disability or related condition. Nursing facility placement is authorized.

(vi) Individual has a primary or secondary diagnosis of dementia without an accompanying condition of an intellectual disability or related condition (if the individual has a diagnosis of an intellectual disability or related condition with dementia, placement is authorized.) Nursing facility placement is authorized.

(vii) Individual is categorically appropriate due to terminal illness, as described in 42 C.F.R. § 418.3, or severe medical condition. Nursing facility placement is authorized.

(viii) Evaluation not completed due to death or discharge. PAS not complete. Medicaid reimbursement for nursing facility services will not be authorized.

(h) Notice of Level II determination.

(i) Notice to facility. The Department shall notify the facility, in writing, of the results of each Level II determination; and

(ii) Notice to individual. The Department shall notify the individual, in writing, of a Level II determination that nursing facility placement is not appropriate. The individual may request a reconsideration regarding the decision that such placement is not appropriate pursuant to the Rules and Regulations of Wyoming Medicaid, Chapter 16, Medicaid Program Integrity.

(i) If a client who has had a Level II within one (1) year is transferred from one nursing facility to another, the transferring facility must copy the Level II documentation and send it with the client as part of the transfer documentation. The admitting facility does not need to complete a Level I or II screening if the client's Level II was completed less than one (1) year before the transfer.

Section 8. Medicaid Reimbursement.

(a) Completion of screening. No facility shall receive Medicaid reimbursement for nursing facility services furnished to a client until:

(i) The completion of the Level I screening which indicates that there is no need for Level II screening or, if the Level I screening indicates the need for Level II screening, the completion of the Level II screening and a determination that nursing facility services are appropriate; and

(ii) The completion of the evaluation of medical necessity pursuant to the Rules and Regulations of Wyoming Medicaid, Chapter 22, Nursing Facility Long Term Care/Home/Community Based Evaluation, which indicates that nursing facility services are medically necessary.

(b) Retroactive payments.

(i) For clients that do not require Level II screening, Medicaid reimbursement shall commence upon receipt by the Department of the results of the Level I screening indicating that there is no need for a Level II screening.

Reimbursement shall be retroactive to the date of the completion of the Level I screening, provided there was an evaluation of medical necessity pursuant to the Rules and Regulations of Wyoming Medicaid, Chapter 22, Nursing Facility Long Term Care/Home/Community Based Evaluation.

(ii) For clients that require Level II screening, Medicaid reimbursement shall commence upon the completion of the Level II screening which indicates that nursing facility services are appropriate, except as specified in Section 7 of this Chapter. Reimbursement shall be retroactive to the date of the completion of the Level II screening, provided there was an evaluation of medical necessity pursuant to the Rules and Regulations of Wyoming Medicaid, Chapter 22, Nursing Facility Long Term Care/Home/Community Based Evaluation. Payments for residents permitted to continue to reside in a facility pursuant to the thirty (30)-month rule, as defined in 42 C.F.R. § 483.130, are subject to the provisions of this paragraph, except that such payments shall be contingent upon the completion of a Level II screening, regardless of whether the screening indicates that nursing facility services are appropriate.

Section 9. Recovery of Overpayments. The Department shall recover overpayments pursuant to the provisions of the Rules and Regulations of Wyoming Medicaid, Chapter 16, Medicaid Program Integrity.

Section 10. Reconsideration. A provider may request reconsideration of the decision to recover overpayments pursuant to the Rules and Regulations of Wyoming Medicaid, Chapter 16, Medicaid Program Integrity.

Section 11. Administrative Hearing.

(a) A provider may request an administrative hearing regarding the final decision pursuant to the Rules and Regulations of Wyoming Medicaid, Chapter 4, Administrative Hearings, of these rules.

(b) An applicant or client may request an administrative hearing pursuant to the Rules and Regulations of Wyoming Medicaid, Chapter 4, Administrative Hearings, regarding the Level II determination of appropriate placement.

Section 12. Delegation of Duties. The Department may delegate any of its duties under this rule to the Wyoming Attorney General, HHS, any other agency of the Federal, State or local government, or a private entity which is capable of performing such functions, provided that the Department shall retain the authority to impose sanctions, recover overpayments or take any other final action authorized by this Chapter.

Section 13. 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 14. Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Department, including manuals and bulletins, which are inconsistent with this Chapter.

Section 15. Severability. If any portion of these rules is found invalid or unenforceable, the remainder shall continue in effect.

WYOMING MEDICAID RULES

CHAPTER XXIII

REIMBURSEMENT FOR COSTS INCURRED BY NURSING HOMES IN IMPLEMENTING THE OBRA ’87 REQUIREMENTS

CHAPTER 23 IS BEING REPEALED

WYOMING MEDICAID RULES

CHAPTER 28

SWING-BED SERVICES

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

Section 2. Purpose and Applicability.

(a) This Chapter has been adopted to govern the provision of and reimbursement of services provided to clients in swing-beds and shall apply to all clients and providers.

(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.

(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 3. Definitions. Except as otherwise specified in the Rules and Regulations of Wyoming Medicaid, Chapter 1, Definitions, the terminology used in this Chapter is the standard terminology and has the standard meaning used in healthcare, Medicaid, and Medicare.

Section 4. General Provisions.

(a) Medicaid reimbursement for swing-bed services and services provided to extraordinary care clients is limited to services furnished to individuals that are nursing facility eligible.

Section 5. Provider Participation.

(a) Payments only to providers. No hospital that provides swing-bed services to a client shall receive Medicaid funds unless the hospital is certified to provide such services has signed a provider agreement and is enrolled.

(b) Compliance with HHS regulations. A hospital that wishes to receive Medicaid reimbursement for swing-bed services furnished to a client must meet the requirements of applicable federal regulations, including 42 C.F.R. § 482.66 and 483.1, et seq.

(c) Compliance with the Rules and Regulations of Wyoming Medicaid, Chapter 3, Provider Participation. A hospital that wishes to receive Medicaid reimbursement for swing-bed services furnished to a client must meet the requirements of the Rules and Regulations of Wyoming Medicaid, Chapter 3, Provider Participation.

Section 6. Provider Records. A provider must comply with the Rules and Regulations of Wyoming Medicaid, Chapter 3, Provider Participation.

Section 7. Verification of Client Data. A provider must comply with the Rules and Regulations of Wyoming Medicaid, Chapter 3, Provider Participation.

Section 8. Pre-admission Screening Resident Review (PASRR).

(a) General requirements. A patient that receives swing-bed services is subject to the requirements of the Rules and Regulations of Wyoming Medicaid, Chapter 19, Nursing Facility Preadmission Screenings.

(b) Failure to timely complete. The failure to timely complete the requirements of the Rules and Regulations of Wyoming Medicaid, Chapter 19, Nursing Facility Preadmission Screenings, shall result in nonpayment for services provided after the date of admission until the date of completion.

(c) Timely completion of PASRR Level II. For clients meeting the criteria of CFR 483.106 (b)(2) as an exempted hospital discharge, the requirements of the Rules and Regulations of Wyoming Medicaid, Chapter 19, Nursing Facility Preadmission Screenings, Section 7, must be satisfied on or before the fortieth (40th) consecutive calendar day after admission.

(d) Failure to timely complete PASRR Level II. The failure to timely complete the requirements of the Rules and Regulations of Wyoming Medicaid, Chapter 19, Nursing Facility Preadmission Screenings, Section 7, shall result in nonpayment for services provided after the fortieth (40th) consecutive day and until the date the PASRR requirements are satisfied.

Section 9. Minimum Data Set (MDS).

(a) General requirements. The MDS requirements, resident assessment required by 42 C.F.R. § 483.20, for nursing facility services shall also apply to swing-bed services. Each provider must comply with the MDS requirements for nursing facility services.

(b) Timely completion. The MDS must be completed on or before the day specified by HHS regulations.

Section 10. Determination of Medical Eligibility. All applicants or clients must undergo an evaluation of medical necessity pursuant to the Rules and Regulations of Wyoming Medicaid, Chapter 22, Nursing Facility Long Term Care/Home/Community Based Evaluation, before a hospital may receive Medicaid reimbursement for services provided to an individual in a swing-bed. Chapter 22 contains the LT-101 requirements.

Section 11. Medicaid Allowable Payment for Swing-bed Services.

(a) The per diem rate for swing-bed services shall be the lower of:

(i) The hospital's usual and customary charges for swing-bed services; or

(ii) The lowest per diem rate currently in effect for nursing facility services furnished in a nursing facility in the community where the hospital is located, as determined pursuant to the Rules and Regulations of Wyoming Medicaid, Chapter 7, Nursing Home Reimbursement System.

(iii) The per diem rate includes reimbursement for all services and supplies furnished to the client, including all services and supplies included in the per diem rates established pursuant to the Rules and Regulations of Wyoming Medicaid, Chapter 7, Nursing Home Reimbursement System (including Attachment A), except as otherwise specified in this Chapter.

(b) A hospital shall not be reimbursed for swing-bed services if:

(i) The client was admitted to the hospital from a nursing facility which has available an appropriate bed to which the client could return;

(ii) There is an available bed in a nursing facility within the hospital's geographic region, as defined in 42 C.F.R. § 413.114(b), and the client has not been transferred as required by Section 13.

(A) "Available bed." A certified bed in a nursing facility that is:

(I) Not occupied by an individual;

(II) Not a reserved bed for which the facility has received or will receive reimbursement; and

(III) In a nursing facility willing and able to provide the services required by the client.

(iii) The hospital is located outside the state of Wyoming; or

(iv) As otherwise prohibited by 42 C.F.R. § 413.114(d).

(c) The facility shall maintain records of the costs it incurs in furnishing swing-beds services. Costs related to swing-bed services shall not be cost settled by Medicaid and shall not be used to rebase inpatient hospital rates pursuant to Chapter 30.

Section 12. Medicaid Allowable Payment for Services Provided to Extraordinary Care Clients.

(a) Medicaid reimbursement for services provided to extraordinary care clients in a swing-bed or nursing facility shall be the per diem rate plus a negotiated rate to cover the cost of medically necessary services and supplies that are not included in the per diem rate.

(i) The Department will negotiate with providers on a case-by-case basis to determine the negotiated rate and the billing procedures for extraordinary care clients.

(ii) Prior to such negotiations, the provider shall submit to the Department:

(A) The required clinical documentation as provided through the Department website and manuals; and

(B) A proposed reimbursement rate, including all relevant financial records and all medical records which document the medical necessity for extraordinary care clients.

(iii) The Department may request, and the provider shall furnish before a negotiated rate is established, additional information to document the medical necessity of extraordinary care.

(iv) The negotiated rate shall be the rate agreed upon by the provider and the Department for medically necessary services.

(v) The Department shall reevaluate the condition of an extraordinary care client after the first fifteen (15) days of admission, again at thirty (30), ninety (90) days and then every six (6) months thereafter. The State shall review records to determine if a renegotiation of the negotiated rate to reflect changes on the client's condition is necessary on a yearly basis. Exceptions to the frequency of reporting are at the discretion of the reviewer. It is the provider's responsibility to report any significant changes in care requirements, condition changes, and/or changes in client physical location at any time prior to the established review.

(b) All inclusive. The negotiated rate shall be an all inclusive reimbursement

rate for all services and supplies furnished by the facility, except as specified in Section 16 and/or as otherwise agreed by the Department.

(c) Maximum rate. The negotiated rate shall not exceed the actual cost of the services provided to the extraordinary care client.

(d) Until the Department agrees, in writing, to a negotiated rate, reimbursement for services provided to an extraordinary care client shall be limited to the per diem rate established pursuant to Section 11 of this Chapter.

(e) The Department's refusal to agree to pay the rate requested by a provider for extraordinary care client is not an adverse action for purposes of the Rules and Regulations of Wyoming Medicaid, Chapter 4, Administrative Hearings.

(f) The facility shall maintain records of the costs it incurs in furnishing services to each extraordinary care client. Costs related to services for extraordinary care clients shall not be cost settled by Medicaid and shall not be used to rebase inpatient hospital rates pursuant to the Rules and Regulations of Wyoming Medicaid, Chapter 30, Level of Care Inpatient Hospital Reimbursement.

Section 13. Transfer to Nursing Facility.

(a) Affected hospitals. All providers of swing-bed services are subject to the requirements of this Section.

(b) Except as provided in subsection (d), an applicant or client receiving swing-bed services must be transferred to the first available, appropriate nursing facility bed in the hospital's geographic region upon the availability date, as defined in 42 C.F.R. § 413.114(b). Medicaid reimbursement to the hospital for swing-bed services shall terminate for services provided after the date of the transfer.

(c) The facility must maintain records of its efforts to transfer each client, including the facility or facilities contacted, and the response(s). Such records shall be maintained as part of the client's medical records kept pursuant to Section 6 of this Chapter.

(d) The requirements of subsection (b) shall not apply if the client's physician certifies, in writing, that transfer is not medically appropriate.

Section 14. Payment of Claims.

(a) General requirements. Payment of claims shall be pursuant to the Rules and Regulations of Wyoming Medicaid, Chapter 3, Provider Participation.

(b) Certification. Each claim must contain a certification by the provider that

the service was medically necessary, that it was provided on the date specified, that third party liability has been paid or, if third party liability has been denied, documentation of that denial is attached, and that the reimbursement sought is not in excess of the provider's usual and customary charge for the service.

Section 15. Medicaid Allowable Payment for Medicaid Program Services.

(a) The Medicaid allowable payment for Medicaid program services furnished to a client receiving swing-bed services shall be determined pursuant to the rules and policies of the Department.

(b) The Medicaid allowable payment for Medicaid program services furnished to an extraordinary care client shall be determined pursuant to the rules and policies of the Department, except:

(i) Inpatient hospital services shall not be reimbursable unless the client is discharged from the swing-bed and admitted to a hospital as an inpatient; and

(ii) As otherwise agreed to by the Department and the hospital pursuant to Sections 12 or 13.

(c) Claims for Medicaid program services shall be submitted pursuant to the rules and policies of the Department.

Section 16. Audits. Audits are subject to the requirements of the Rules and Regulations of Wyoming Medicaid, Chapter 16, Medicaid Program Integrity.

Section 17. Medical Necessity Reviews.

(a) The Department may review medical records or conduct on-site medical necessity reviews to determine whether the services a patient is receiving are medically necessary.

Section 18. Recovery of Overpayments. The Department shall recover overpayments pursuant to the provisions of the Rules and Regulations of Wyoming Medicaid, Chapter 16, Medicaid Program Integrity.

Section 19. Reconsideration. A provider may request reconsideration of the decision to recover overpayments pursuant to the provisions of the Rules and Regulations of Wyoming Medicaid, Chapter 16, Medicaid Program Integrity.

Section 20. Delegation of Duties. The Department may delegate any of its duties under this rule to the Wyoming Attorney General, HHS, any other agency of the Federal, State or local government, or a private entity which is capable of performing such functions, provided that the Department shall retain the authority to impose

sanctions, recover overpayments or take any other final action authorized by this Chapter.

Section 21. 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 various provisions.

Section 22. Superseding Effect. This Chapter supersedes all prior rules or policy statements issued by the Department, including manuals and/or bulletins, which are inconsistent with this Chapter.

Section 23. Severability. If any portion of these rules is found invalid or unenforceable, the remainder shall continue in effect.