

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 July 1, 2015.

(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.

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 health care, 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 non-allowable 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 (5th) 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-K). The per diem rate shall not be computed, however, until the receipt of the information specified in subsections (c)(iii)(A-K). 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. The version of the Medicare cost report submitted to Wyoming Medicaid shall agree to the cost report submitted to Medicare.

(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

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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-K) 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-K) 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;

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(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;

(J) Wyoming Financial Report for Long Term Care, a supplemental cost reporting form specific to the Medicaid program; and

(K) 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-K) 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

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. New Facilities and Changes of Ownership Per Diem Rate Determination.

(a) New nursing facilities. A newly constructed facility for a provider that did not previously exist, 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

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certified. An addition to a certified facility is not a "new facility." An existing provider that constructs a new building to move into is not a "new facility" but the new building may be subject to a re-age adjustment per Section 18.

(i) A new nursing facility rate shall be calculated by rate category as follows:

(A) Health care portion of rate. The new facility will receive the same starting price as all other facilities with a quarterly case mix adjustment using the new provider's case mix scores. If the provider does not have the qualifying case mix data at the time rates are calculated, the health care component will be calculated using the statewide Medicaid average case mix score from the prior quarter.

(B) Capital portion of rate. The new facility will receive a property rental rate based on the age of their building. If the age cannot be determined at the time of rate-setting or if the provider does not supply the appropriate data to calculate the age of the building when requested, the provider will receive a property rental rate based on a 40-year old building. The rate will not be adjusted retrospectively if the provider later supplies the needed documentation. The rate will be adjusted to reflect the revised age at the beginning of the next rate quarter.

(C) Exempt portion of rate. The new facility will receive the exempt portion of their rate using the statewide average calculated in the previous quarter.

(D) Operating portion of rate. The new facility will receive the same fixed price the rest of the state is receiving for that quarter.

(ii) A new nursing facility's rate will be calculated in this manner until the provider has a qualifying cost report on file that has been subjected to audit. At that time, the qualifying cost report will be used to set their rate effective with the July 1 rate cycle in accordance with Section 13(c).

(b) Change of ownership.

(i) A nursing facility which has a change of ownership shall receive a rate calculated as follows:

(A) Health care portion of rate. The new owner will receive the same starting price as all other facilities with a quarterly case mix adjustment using the new owner's case mix scores. If the new owner does not have the qualifying case mix data at the time rates are calculated, the health care component will be calculated using

the prior owner's Medicaid average case mix score from the most recently available quarter.

(B) Capital portion of rate. The new owner shall assume the building age used for the property rental rate from the prior owner and receive a property rental rate in accordance with Section 18.

(C) Exempt portion of rate. The new owner will assume the exempt portion of the per diem rate using the most currently available audited data from the prior owner.

(D) Operating portion of rate. The new owner will receive the same fixed price the rest of the state is receiving.

(ii) The rate will be calculated in this manner until the provider has a qualifying cost report on file that has been subjected to audit. At that time, the qualifying cost report will be used to set their rate effective with the July 1 rate cycle in accordance with Section 13(c).

(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 re-determined 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 and Rate Categories.

(a) General requirements. Costs shall be allocated among the following cost components as specified in this section: (1) health care costs; (2) capital costs; (3) exempt costs; and (4) 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. Reimbursement will be a combination of a cost based system and a fixed price system as described in Section 15.

(b) Health care 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. This rate component is subject to a quarterly case mix acuity adjustment.

- (i) Medical records;
- (ii) Social services;
- (iii) Direct nursing health care labor costs for the following:
 - (A) Registered nurses;
 - (B) Licensed practical nurses;
 - (C) Nurse assistants and certified nurse assistants;

(D) Contracted nurses;

(iv) Payroll taxes and employee benefits associated with the wages 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) Exempt cost component. The exempt cost component consists of:

(i) Property taxes. The cost of property taxes on assets used in providing patient care is allowable. Tax penalties, late fees, and income taxes are not allowable;

(ii) Property insurance. The cost of property insurance on assets used in providing patient care is allowable. Malpractice, workmen's compensation, and other employee-related insurances are not considered property insurance;

(iii) Utilities. Heat, electricity, water, sewer, and garbage.

(iv) Nurse aide training. Costs for testing, books, fees, and classes for completing the Nursing CNA exam. Wages and benefits of employees while they are being trained are not considered an exempt cost and will be included in health care costs with other nursing wages. Other training and refresher courses are not includable as exempt and should be reported in health care costs. In-house trainer wages will not be included as exempt and should be included in the health care cost center.

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

(i) Administrative and general costs, including home office costs and management fees;

(ii) Plant operations;

- (iii) Laundry;
- (iv) Housekeeping;
- (v) Cafeteria;
- (vi) Dietary;
- (vii) Nurse administration;
- (viii) Central services, routine supplies, and non legend drugs;
- (ix) Pharmacy consultant;
- (x) Activities
- (xi) Payroll taxes and employee benefits associated with the wages above.
- (xii) Medical director
- (xiii) All other allowable costs not mentioned in (b), (c), and (d) in this section.

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 the minimum amount utilized by Medicare for cost reporting, which is currently five thousand dollars (\$5,000), 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) Investment income offset. Interest allowable pursuant to this

section must be reduced by investment income pursuant to the PRM.

(iii) 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.

(d) 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 cost should be adjusted to the actual cost incurred by the related party.

(e) 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. Working Capital Interest.

(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.

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

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;

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(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 provided on or after July 1, 2015, a provider's per diem shall become effective on the rate effective date, which is July 1 of each year, with quarterly acuity case mix adjustments. Per diem rates are established prospectively and shall remain in effect from the rate effective date until re-determined 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 field audit, or legislative budget change.

(c) Applicable cost report data. The data used in establishing the rate calculation effective each July 1 is from the cost reports which ended two (2) calendar years ago (for example, cost reports ending during the period from January 1, 2013 to December 31, 2013, will be used to set rates effective July 1, 2015).

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- (d) Rates will be adjusted quarterly to reflect case mix acuity adjustments.
- (e) Notice of rate. The Department shall notify providers of the per diem rate by certified mail, return receipt requested.
- (f) If there is a need to issue an interim rate, the rate will be issued as interim and the rate will later 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.
- (c) The database shall separate costs from the reviewed or audited cost report into the categories for (1) health care costs; (2) capital costs; (3) exempt costs; and (4) operating costs as defined in Section 9.
- (d) Bed ranges. Providers will be grouped by bed range group. Providers will be grouped into ranges based on the number of licensed beds.

Section 15. Price and Rate Setting – Legislative Appropriation.

- (a) Reimbursement will be a combination of a prospective fixed price system and a cost-based system with the health care component subject to an acuity adjustment. The legislature will provide an annual budget each year. The budget will be used to set the cost and price based rates as follows:
- (b) Property Price. The first round of legislative allocations will be used to determine the reimbursement necessary to fund the price-based property rental rate system. The property rental rate methodology is defined at Section 18 of this Chapter.
- (c) Exempt Cost Per Diem. The second round of allocations will be to determine the reimbursement necessary to fund the exempt cost-based reimbursement

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category. Exempt costs are defined at Section 9(d) of this Chapter.

(d) Health care and Operating Prices. The balance of the legislative appropriation will be used to fund the prices for the health care and operating categories. The balance of the funding will be allocated between the operating and health care categories based on the statewide total percentage of audited or desk reviewed costs classified to these categories.

(i) The operating price will be the same price reimbursed to all providers, regardless of their cost.

(ii) The health care price will begin with the same price to all providers, regardless of their cost. Each provider's starting price will be further adjusted up or down based on the provider's case mix acuity score for each quarter as is described in Section 16.

(e) Rates will be adjusted quarterly with the only change in the rate being the case mix adjustment to the health care component.

(f) Rates will be further adjusted by bed range group. Each group will receive a percentage adjustment increase or decrease so the resulting cost coverage averages of each group are within + or - 3% of each other.

(g) The state may, due to budget reasons, adjust rates in the last quarter to reflect legislative funding.

Section 16. Health Care Case Mix Acuity Adjustment.

(a) Health care prices will be paid using a starting fixed price that is the same for all facilities. The fixed price will be adjusted for each individual provider on a quarterly basis based on each facility's Medicaid case mix index to reflect the case mix of that facility's Medicaid residents in a certain quarter. The case mix adjustment will be calculated by taking the fixed starting price times each provider's weighted average Medicaid case mix index divided by the statewide average Medicaid case mix index for each quarter.

(b) Applicable Case Mix Index (CMI). The Medicaid CMI used in establishing each facility's rate is calculated based on the weighted average assessment for each Medicaid resident in the nursing facility in the prior quarter where an MDS assessment was completed and successfully transmitted to the QIES ASAP system. The CMI is recalculated quarterly and each nursing facility's health care component rate is adjusted accordingly.

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(c) Minimum Data Set (MDS). A set of screening, clinical, and functional status elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in Medicare or Medicaid. The version of the assessment document used for rate setting is version 3.0. Subsequent versions of the MDS will be evaluated and incorporated into rate setting as necessary.

(d) Case Mix Index (CMI). A numeric score assigned to each nursing facility resident, based on the resident's physical and mental condition that projects the amount of relative resources needed to provide care to the resident.

(i) The department shall employ the Resource Utilization Group IV (RUG IV), 48 Group case mix classification methodology.

(ii) For the 7/1/15 rate quarter, the case mix weight will use the most current MDS assessment for all Medicaid residents as of 04/01/15. Beginning with the 10/01/15 quarter and all subsequent quarters, the case mix weight for each resident of a nursing facility for each prior quarter shall be based on data from MDS assessments completed for the resident and accepted into the QIES ASAP System and weighted by the number of days the resident assessment was in each case mix classification group.

(A) A default case mix group shall be established for cases in which the resident dies or is discharged prior to completion of the resident's initial assessment. The default case mix group and case mix weight for these cases shall be designated by the department.

(B) A default case mix group shall also be established for cases in which there is an untimely assessment for the resident. The default case mix group and case mix weight for these cases shall be designated by the department.

(iii) The facility Medicaid case mix average shall be determined by multiplying the case mix weight of each Medicaid resident by the number of days the resident was at each particular case mix classification group, and then averaging.

(A) The payment source for a resident assessment is considered to be Medicaid if the assessment is a non-PPS assessment where MDS item A0700 Medicaid Number is submitted with a valid Medicaid number.

(B) State-Wide Average Medicaid Case Mix Index. The simple average of all nursing facilities Medicaid case mix indexes used in establishing the reimbursement limitation each quarter.

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(e) Nursing Facility: MDS Reviews. The following Minimum Data Set (MDS) reviews will be conducted.

(i) Facility Review. Prior to the rate quarter, each facility will be sent a Preliminary report of its resident roster, a listing of residents' assessments, RUG classification, number of days for the RUG classification, case mix index, and payment source. It will be the facility's responsibility to review the roster for accuracy and to submit missing assessments or corrections to the QIES ASAP system prior to the final processing. Once the resident roster has been used for rate setting, it will be considered final.

(ii) Departmental Review. If a departmental review of the MDS data reveals errors that result in an incorrect case mix index, the provider's rate will be retroactively adjusted, for all quarters containing the incorrect assessment, and an amount due to or from the Department will be calculated. This does not include residents who received the default classification due to incomplete or inconsistent MDS data.

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 July 1, 2015, as follows:

(b) 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.

(c) Except as otherwise specified in (a), a provider shall receive four (4) rate changes per year on the quarterly 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(e) 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 budget provided by the legislature.

Section 18. Determination of Property Rental Rate Price.

(a) Property Rental Rate. Nursing facilities will be paid a price-based per

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diem rate based on the age of each provider's building. The property rental rate is paid in lieu of reimbursement for capital costs defined at Section 9(c). The property rental rate does not reimburse for property taxes and property insurance. Property taxes and property insurance will be reimbursed as an exempt costs as defined at Section 9(d).

(b) The property rental rates for each building age were calculated in 2015. 2015 will serve as the base year for each provider's building age and rental rates effective July 1, 2015 through June 30, 2016. Base year 2015 rental rate per diems by building age are shown in the table below.

Age	Rate	Age	Rate	Age	Rate	Age	Rate
0	15.55	11	14.20	22	12.85	33	11.50
1	15.43	12	14.08	23	12.73	34	11.38
2	15.30	13	13.95	24	12.60	35	11.25
3	15.18	14	13.83	25	12.48	36	11.13
4	15.06	15	13.71	26	12.36	37	11.01
5	14.94	16	13.59	27	12.24	38	10.89
6	14.81	17	13.46	28	12.11	39	10.76
7	14.69	18	13.34	29	11.99	40	10.64
8	14.57	19	13.22	30	11.87	40+	10.64
9	14.45	20	13.10	31	11.74		
10	14.32	21	12.97	32	11.62		

(c) The rates in the table above will be used for rate setting beginning on July 1, 2015. Building ages will all increase by one (1) year every July 1, beginning on July 1, 2016, regardless of the original construction date.

(d) Annual Property Rental Rate Adjustment. Annually on July 1, subject to legislative funding, the prior year rates for each building age will be adjusted up or down by the percentage change published in the Marshall Swift index. The percentage change will be determined using the "Annual Cost Changes" published in the "Current Building Cost Indexes" section of the Marshall Swift Valuation service publication, or its successor. The Annual Cost Changes category used will be for the Western Region, Class D, Nursing Home (convalescent hospital) group. The most recent publication available at the time of rate setting will be used for the annual rate adjustment.

(e) Age of the building. Facilities that existed and participated in Medicaid as of March 2015 were assigned a facility age as of 2015 based on the results of a capital cost survey that was held in 2013 and updated in 2015. The base year ages will not be adjusted due to lack of provider participation or cooperation in the survey.

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(f) Buildings with an adjusted age greater than 40 years will be reimbursed as a 40-year old building.

(g) New providers that do not have an existing building age. The age of the building will be determined based on a request for documentation relating to the historical construction date, square footage, and costs of material capital additions.

(i) Adequate documentation will include, but not be limited to, such documents as copies of building permits, tax assessors' records, receipts, invoices, building contract, and original notes of indebtedness, total square feet, depreciation schedule, and any other document deemed necessary.

(ii) If adequate information is not submitted by the facility by 30 days prior to the beginning of the next rate quarter to document that the facility, or portion thereof, is newer than forty (40) years, the age will be set at forty (40) years. If adequate documentation is provided later, and if it results in a revised age, the age will be reflected on the first day of the next rate quarter after the documentation is reviewed.

(h) Re-age Adjustment. For rates paid after the July 1, 2015 calendar quarter, the effective age of a facility may be further adjusted when the cost of major repairs, replacement, remodeling, or renovation of a building results in the change in age by at least one (1) year when applied to the formula in Section 18 (h)(iv) of this chapter.

(i) It is the provider's responsibility to notify the Department and document costs, square footage, and any other item needed for the review. The Department may adjust the age after a review of the documented costs and construction is made.

(ii) Re-age adjustments of one (1) year will become effective with the next July 1 rate effective date. Re-age adjustments of two (2) or more years will be effective on the first day of the following rate quarter after the re-age calculation is completed. At no time will the re-age adjustment be made retrospectively or mid-rate quarter.

(iii) Projects will not qualify for a re-age adjustment until all of the costs have been capitalized and the project has been placed into service.

(iv) Re-age adjustment formula. The re-age adjustment is calculated using the following formula: $R = 40 \times E / S \times C$, where

R =	Re-age adjustment.	The reduction of age of the facility in years.
E =	Actual expenses for the construction	Expenses related to capitalized assets for fixed assets including landscaping, sidewalks, egresses, retaining walls, and parking lots. The total costs must have been incurred within twenty-four (24) months of the completion of the construction. For larger construction projects or additions, 36 months may be granted at the State's discretion.
S =	Total square footage in the building	Gross square feet including common area at the end of the construction.
C =	The cost of construction for the building in the year the construction was completed.	Source is from costs published by Marshall & Swift Valuation Service or its successor. Costs reflect current construction costs for average Class D Nursing Home (convalescent hospital) using the most current publication. If the publication is late at the time of rate setting, the prior year amount will be inflated forward using the "Annual Cost Changes" figure identified in Section 18 (d).

(v) If the result of this calculation, "R" is equal to or greater than 1.0, the age of the building in years will be reduced by this number, rounded to the nearest whole number for rate setting purposes. In no case will the age be less than zero (0).

(vi) Re-age Adjusted Building Age. The beginning age of the building minus the re-age adjustment is defined as the "re-age adjusted building age." This age is used to select the rental rate based on the age of the building.

(i) Funding Limit Property Rental Rate Rebase. If at the time the July 1 rates

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are being calculating using the base year property adjusted to the current rate year results in total property reimbursement equating to more than 10% of the total legislative budget, the property rental rates will be rebased to a lower amount as determined by the state to shift those legislative dollars from the property category to the health care and operating rate categories.

Section 19. Wyoming Retirement Center.

The state operated facility will be subject to all rules within this chapter with the exception of the rate and price setting Sections 7, 13(d), 14, 15, 16, 17(c), and 18.

(a) Per diem rates shall be calculated separately from other facilities in this chapter and the Wyoming Retirement Center data will not be included in the database of providers identified in Section 14.

(b) The provider's per diem rate shall be determined utilizing either a desk reviewed or audited cost report. Costs will not be subject to any form of cap or maximum rate.

(i) Effective date. For services effective on or after July 1, 2015, the provider's per diem rate shall become effective on the rate effective date.

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

(iii) The most currently reviewed cost report will be used to set the future rate. The same year will not be used twice.

(c) Rates shall be established by inflating the audited or desk reviewed costs from the midpoint of the provider's cost reporting year to the midpoint of the rate year. Inflated costs will be divided by total patient days to arrive at the allowed per diem rate.

(d) "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. Hold Harmless.

(a) If the provider's July 1, 2015 calculated rate is less than their rate in effect on June 30, 2015, the provider will qualify for a hold harmless rate adjustment as follows:

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(b) For the rate quarters effective on July 1, 2015 and October 1, 2015, the provider will continue to receive their rate that was in effect on June 30, 2015.

(c) For the rate quarters effective on January 1, 2016 and April 1, 2016, the provider will receive their rate that is calculated for the rate quarter using the rate methodology effective for that quarter plus 50% of the difference between that rate and their rate that was effective on June 30, 2015.

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

(c) The department shall follow the existing reimbursement methodology and increase the cost components to reimburse the providers for the legislative appropriation.

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 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 (equipment and staffing) and supplies that are not included in the per diem rate.

(i) The only items that may qualify for an extraordinary rate are as follows:

- (A) Tracheostomy
- (B) Ventilator
- (C) Morbid obesity

(D) Psychiatric care for clients with significant behaviors that cannot otherwise be safely cared for in a standard nursing facility setting without increased staffing or special accommodations. This includes clients with significant physical aggression, delirium and/or psychosis.

(ii) 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.

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

- (A) A treatment plan;
- (B) A proposed reimbursement rate, including all relevant

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financial records and all medical records which document the medical necessity for services provided to an extraordinary care client; and

(C) All other specific documentation required by the Department for processing of the rate request.

(iv) 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.

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

(vi) 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.

(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 for Distressed Facilities.

(a) The Department may pay a contracted rate to a nursing facility determined by the Department to be in distress. The contracted rate may exceed the nursing facility's

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per diem rate as determined pursuant to Section 17 of this Chapter.

(b) The Department shall negotiate and enter into contracts for a temporary contracted rate using the following procedures:

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

(A) Factors:

- (I) Financial stability and solvency;
- (II) Occupancy (low occupancy as a percentage of capacity or drops quickly);
- (III) Whether or not the Department has assumed temporary management of the facility; and
- (IV) Geographic location of the 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;

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

(IX) Maintenance of the provider network in rural or underserved areas; and

(X) Avoidance of client abandonment by the dissolution or insolvency of the incumbent provider.

(ii) Solicit proposals for the temporary rate contracts; and

(iii) Negotiate with providers.

(c) The Department will negotiate with providers determined to be in distress on an individual basis to determine whether a contracted rate is appropriate for that nursing facility, using the Department's distressed facility criteria.

(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 distressed status of the facility;

(II) A proposed method of monitoring and building overall census, 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 maintain required daily operations in compliance with all State and Federal provisions.

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

(iii) The contracted rate shall be the rate agreed upon by the provider and the Department for the maintenance of daily operations focused on client health and safety. The rate shall apply to all Medicaid clients in the nursing facility, unless otherwise agreed by the Department.

(iv) The Department may establish monitoring criteria and procedures to determine whether the facility continues to maintain client health and safety.

(v) If the Department determines that the client's health and safety are not being maintained in accordance with State and Federal standards, the Department shall suspend the nursing facility's temporary rate contract and work with the Office of Healthcare Licensing and Survey to take appropriate action. The contracted temporary rate shall be the rate set for new ownership of a distressed facility pending the return of overall facility census to prior year's operating levels (as documented by the Department) or for up to a maximum of six (6) months. Upon expiration of the temporary contracted rate, the Department may, at its discretion, re-evaluate the continued need for a temporary rate for up to six (6) additional months or terminate the temporary rate contract. Upon final termination, the Department shall reinstate 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.

(E) State owned facilities will be exempt from this program.

(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 on schedule B of this same cost report. For providers who do not file Medicare cost report, Assessment expenses shall be reported on line 578 of the State of Wyoming Financial Report for Nursing Homes annual cost report.

(F) State owned facilities will be exempt from this program.

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.

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(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 if that cost report is needed for rate setting. 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 Medicaid day weighted average rate in effect in

Wyoming as of the previous July 1; or

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

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

(i) Multiplying the number of Medicaid days in each nursing facility by each facility's Medicaid per diem rate;

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

(iii) Dividing the sum determined pursuant to (ii) by the total number of Medicaid days 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.

(e) The calculated rate will remain in effect until the following July 1. Out of state providers are not subject to quarterly case mix acuity adjustments.

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 (60th) 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

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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.

(XXXI) Costs of services or supplies provided by a related party are reimbursable at the actual cost incurred by the related party. If the actual cost cannot be determined, the profit percentage from the related party's records will be used to calculate the profit percentage adjustment to the related party cost.

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

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services; and

- (1) Actually performed;
- (2) Necessary to the delivery of patient-related

- (3) The compensation paid was reasonable.

- (4) 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.

- (5) 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.

- (6) 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).

- (7) 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.

(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.

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Supersedes: TN NO. 10-008 all, 02-005 all, 11-002, and 96-001 Attachment A-1, A-2 and A-3

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ATTACHMENT A

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
Aquamatic 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
Cannula, 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

- 2) That reductions in provider payment may be limited to the extent that the following apply:
- (i) The identified provider-preventable conditions would otherwise result in an increase in payment.
 - (ii) The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.
- 3) Assurance that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

In the event that individual cases are identified throughout the PPC implementation period, the State will adjust reimbursements according to the methodology above. Denial of payment shall be limited to the additional care required by the provider preventable condition.

____ Additional Other Provider-Preventable Conditions identified below *(please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services)* of the plan:

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-New. The time required to complete this information collection is estimated to average 7 hours per response, including the time to complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

TN No. 12-002
Supercedes
TN No. NEW
CMS ID: 7982E

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Effective Date 07/01/12

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

Wyoming Medicaid meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions (OPPCs) for non-payment under Section(s) 4.19(d):

 X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Wyoming Medicaid will adopt the baseline for other provider-preventable conditions as described above. The following reimbursement changes will apply:

Payment will be denied for these conditions in any Health Care Setting as identified in Attachment 4.19(d) and any other settings where these events may occur. For any Wyoming Medicaid claims with dates of service after July 1, 2012, Wyoming Medicaid will follow the minimum CMS regulations in 42 CFR §447 and deny payment for all of the OPPCs identified in 42 CFR §447. Wyoming Medicaid will retroactively review claims with dates of service on or after July 1, 2012, to identify claims fitting the criteria for PPCs. Wyoming Medicaid will request that providers review claims identified as potential PPCs and provide additional documentation to confirm or deny the claim includes a PPC. For any provider-confirmed PPCs, payment will be adjusted to recoup the payment for the patient day(s) during which the PPC event occurred. Recoupment will be for the amount of the per diem that was in effect for the date(s) of service that the PPC event occurred.

In compliance with 42 CFR 447.26(c), Wyoming Medicaid provides:

- 1) That no reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

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STATE: WYOMING

Section 1. Authority.

This rule is promulgated by the Department of Health and Social Services pursuant to the Medical Assistance and Services Act at W.S. 42-4-101 et seq) and the Wyoming Administrative Procedures Act at W.S. 16-3-101 et seq.

Section 2. Applicability.

This rule shall apply to and govern the reimbursement of the Wyoming Life Resource Center State Operated Facility and other ICFs/ID for services provided on or after July 1, 2015.

Section 3. General Terms. These rules are intended to implement and be read in conjunction with the provisions of W. S. 42-4-103(a)(xxii).

Section 4. Definitions.

- (a) "Certified." Approved by the Department to provide ICF/ID services.
- (b) "Excess payments." Medicaid funds received by a provider:
 - (i) That exceed the provider's per diem rate;
 - (ii) Pursuant to a per diem rate which is subsequently determined to be erroneous or based on erroneous information; or
 - (iii) Pursuant to an interim payment rate that is based on projected costs which exceed the facility's actual costs for the interim payment rate period.
- (c) "Facility." An ICF/ID.
- (d) "Infirmity services." Sub-acute hospital services provided on the premises of a facility.
- (e) "Interim payments." Payments to a new facility or a newly certified facility pursuant to subsection 5(c) during the time between the effective date of the new facility's provider agreement and the determination of a per diem rate pursuant to this rule.
- (f) "Intermediate care facility for people with Intellectual Disability (ICF/ID)." An intermediate care facility as defined by 42 U.S.C. 1396d(c) that has at least fifteen certified beds. "ICF/ID" includes that portion of the Wyoming Life Resource Center which is certified to provide intermediate care facility services for those with intellectual disabilities.
- (g) "Per diem rate." The Medicaid reimbursement rate determined pursuant to this rule.

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(h) "Provider." An ICF/ID that has a provider agreement with the Department and that is certified to provide services to recipients.

(i) "Provider agreement." A formal written agreement between the Department and an ICF/ID that is certified to provide services to recipients.

(j) "Services." Intermediate care facility services for those with intellectual disabilities as defined in 42 U.S.C. 1396d(d).

(k) "Services and supplies included in the per diem rate." In addition to those services and supplies specified in Chapter 7, Attachment A, which is hereby incorporated by reference, unique costs are included in the per diem rate.

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

- (i) Barber and beauty shop services;
- (ii) Clothing;
- (iii) Cigarettes, cigars, pipes and tobacco;
- (iv) Cosmetics;
- (v) Hospital services;
- (vi) Prosthetic devices;
- (vii) Ventilators; and
- (viii) Customized wheelchairs that are fitted or fabricated to a specific individual and cannot be used by any other person, and electric wheelchairs, including batteries.

(m) "Temporary absence." When a recipient is out of a facility for hospitalization or therapeutic home visits. Temporary absences for hospitalization: (a) shall not exceed fifteen days per year, and (b) the recipient must intend to and have a reasonable expectation of returning to the facility. Temporary absences for therapeutic home visits must: (a) be part of the recipient's plan of care, and (b) shall be limited to fifteen days in duration no more than once per month, not to exceed thirty days per calendar year. A recipient receiving infirmary services is not absent from the facility.

(n) "Unique costs." The following services and supplies are unique costs and shall be included in the per diem rate if they are provided by the facility or by a third party under contract to the facility to or for the benefit of a recipient:

- (i) Audiology services;

- (ii) Case management services;
- (iii) Dental services;
- (iv) Dietary services and adaptive equipment;
- (v) Dry cleaning expenses incurred on behalf of residents;

- (vi) Habilitation services;
- (vii) Hearing aids;
- (viii) Infirmary services;
- (ix) Laboratory services;
- (x) Music therapy services;
- (xi) Occupational therapy services;
- (xii) Optical services;
- (xiii) Orthotic services;
- (xiv) Physical therapy services;
- (xv) Physician services;
- (xvi) Podiatry services;
- (xvii) Prescription drugs;
- (xviii) Pre-vocational training services and supplies;
- (xix) Psychological services;
- (xx) Recreational therapy services;
- (xxi) Social services;
- (xxii) Speech therapy services; and
- (xxiii) Transportation services.

(o) "Wyoming Life Resource Center." The Wyoming state training school as established pursuant to W.S. 25-5-101 et seq.

Section 5. General methodology.

(a) Incorporation of Chapter VII. ICFs/ID shall be reimbursed using a per diem rate calculated in accordance with the methodology established below. In addition, ICFs/ID shall be subject to the rules in Chapter VII, the Wyoming Nursing Home Reimbursement System, except as otherwise specified by this rule. Chapter VII is hereby incorporated by reference, excluding the rate and price setting Sections 7, 13(d), 14, 15, 16, 17(c), 18, and 19 and with the modifications specified in this Chapter.

(b) Calculation of per diem rates for ICFs/ID. The per diem rate for ICFs/ID shall be calculated independently from the calculation of rates for facilities as defined in Chapter VII. The provider's per diem rate shall be determined utilizing either a desk reviewed or audited cost report. Costs will not be subject to any form of cap or maximum rate for the Wyoming Life Resource Center.

(i) Effective date. For services effective on or after July 1, 2015, a provider's per diem rate shall become effective annually on July 1. The rates calculated each July 1 will remain in effect until the following July 1.

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

(iii) Applicable cost report data. The data used in establishing the rate calculation effective each July 1 is from the cost reports which ended two (2) calendar years ago (for example, cost reports ending during the period from January 1, 2013 to December 31, 2013, will be used to set rates effective July 1, 2015).

(iv) Cost reports submitted by ICFs/ID shall not be used in any way to calculate per diem rates for facilities as defined in Chapter VII.

(iv) Rates shall be established by inflating adjusted / reviewed costs from the midpoint of the provider's cost reporting year to the midpoint of the rate year. Inflated costs will be divided by total patient days to arrive at the allowed per diem rate.

(c) Reimbursement of new facilities. A new facility or a newly certified facility shall receive interim payments for services provided to recipients as determined pursuant to this subsection.

(i) Submission of projected costs. A new facility shall, before receiving Medicaid funds for services provided to recipients, submit a cost report to the Department containing projected costs for the facility's first six months of operation.

(ii) Time of submission of cost report. A new facility shall submit a cost report containing the information specified in paragraph (i) within sixty days after the facility notifies the Department in writing that it wishes to participate in the Medicaid program as a provider and has been certified.

(iii) Review of projected costs. The Department shall desk audit the cost report submitted pursuant to paragraph (i) to determine the reasonableness of the facility's allowable projected costs. An interim payment rate shall be established using the facility's reasonable, allowable costs. The interim payment rate shall not exceed the lower of the rate determined pursuant to this subsection and 75% of the Wyoming Life Resource Center rate in effect.

(iv) Period of interim payments. Interim payments shall be effective upon the effective date of the facility's provider agreement, and shall remain in effect until a qualifying cost report has been submitted and subjected to audit and used to calculate a rate. No payments shall be made to a new facility until an interim payment rate has been determined pursuant to this subsection.

(v) Audits of interim payments. Upon receipt of the qualifying cost report, the Department may audit a facility to determine the accuracy and reasonableness of cost reports submitted by the facility. If the audit discloses that the interim payments included non-allowable costs, costs for services and supplies not included in the per diem rate or that budgeted costs exceeded actual costs, the Department shall adjust the per diem rate retroactively to the beginning of the interim rate period and recover any excess payments.

(vi) Audits will be conducted in accordance with Section 5(b). Providers other than Wyoming Life Resource Center will have rates limited to the lower of the provider's audited cost in accordance with Section 5(b) or 75% of the Wyoming Life Resource Center rate.

Section 6. Incorporation of Chapter XVII. ICFs/ID are subject to the requirements of Chapter XVII, Nursing Facility Resident Trust Accounts, which is hereby incorporated by reference.

Section 7. Severability. If any portion of these rules is found to be invalid or unenforceable, the remainder shall continue in effect.