Notice of Intent to Adopt Rules

A copy of the proposed rules may be obtained at http://rules.wyo.gov

Revised May 2018

1. General Information

a. Agency/Board Name*
Wyoming Department of Health

b. Agency/Board Address	c. City	d. Zip Code
401 Hathaway Building	Cheyenne	82002

e. Name of Agency Liaison	f. Agency Liaison Telephone Number
Sheila McInerney	307-777-5389

g. Agency Liaison Email Address
sheila.mcinerney@wyo.gov

h. Date of Public Notice	i. Comment Period End Date
November 5, 2018	December 20, 2018

j. Public Comment URL or Email Address:
sheila.mcinerney@wyo.gov

k. Program
Medicaid

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

2. Legislative Enactment

For purposes of this Section 2, "new" only applies to regular rules promulgated in response to a Wyoming legislative enactment not previously addressed in whole or in part by prior rulemaking and does not include rules adopted in response to a federal mandate.

a. Are these rules new as per the above description and the definition of "new" in Chapter 1 of the Rules on Rules?

☐ No. ■ Yes. Please provide the Chapter Numbers and Years Enacted
(eg: 2015 Session Laws Chapter 154): HEA 59, 2018 Budget Session

3. Rule Type and Information

a. Provide the Chapter Number, Title, and Proposed Action for Each Chapter.
Please use the Additional Rule Information form for more than 10 chapters, and attach it to this certification.

Chapter Number:	Chapter Name:	
35	Medicaid Benefit Recovery	☐ New ■ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed

4. Public Comments and Hearing Information

a. A public hearing on the proposed rules has been scheduled. ■ No. ☐ Yes. Please complete the boxes below.

Date:	Time:	City:	Location:

b. What is the manner in which interested persons may present their views on the rulemaking action?

■ By submitting written comments to the Agency at the physical and/or email address listed in Section 1 above.

☐ At the following URL: _____

A public hearing will be held if requested by 25 persons, a government subdivision, or by an association having not less than 25 members. Requests for a public hearing may be submitted:

■ To the Agency at the physical and/or email address listed in Section 1 above.

☐ At the following URL: _____

c. Any person may urge the Agency not to adopt the rules and request the Agency to state its reasons for overruling the consideration urged against adoption. Requests for an agency response must be made prior to, or within thirty (30) days after adoption, of the rule, addressed to the Agency and Agency Liaison listed in Section 1 above.

5. Federal Law Requirements

a. These rules are created/amended/repealed to comply with federal law or regulatory requirements. ■ No. ☐ Yes. Please complete the boxes below.

Applicable Federal Law or Regulation Citation:

Indicate one (1):

■ The proposed rules meet, but do not exceed, minimum federal requirements.

☐ The proposed rules exceed minimum federal requirements.

Any person wishing to object to the accuracy of any information provided by the Agency under this item should submit their objections prior to final adoption to:

■ To the Agency at the physical and/or email address listed in Section 1 above.

☐ At the following URL: _____

6. State Statutory Requirements

a. Indicate one (1):

■ The proposed rule change *MEETS* minimum substantive statutory requirements.

☐ The proposed rule change *EXCEEDS* minimum substantive statutory requirements. Please attach a statement explaining the reason that the rules exceed the requirements.

b. Indicate one (1):

☐ The Agency has complied with the requirements of W.S. 9-5-304. A copy of the assessment used to evaluate the proposed rules may be obtained:

☐ By contacting the Agency at the physical and/or email address listed in Section 1 above.
☐ At the following URL: _____

■ Not Applicable.

7. Additional APA Provisions

a. Complete all that apply in regards to uniform rules:

☒ These rules are not impacted by the uniform rules identified in the Administrative Procedure Act, W.S. 16-3-103(j).

☐ The following chapters do not differ from the uniform rules identified in the Administrative Procedure Act, W.S. 16-3-103(j):

_____

(Provide chapter numbers)

☐ These chapters differ from the uniform rules identified in the Administrative Procedure Act, W.S. 16-3-103(j) (see Statement of Principal Reasons).

_____

(Provide chapter numbers)

b. Checklist

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

☐ If applicable: In consultation with the Attorney General's Office, the Agency's Attorney General representative concurs that strike and underscore is not required as the proposed amendments are pervasive (Chapter 3, *Types of Rules Filings*, Section 1, Proposed Rules, of the Rules on Rules).

8. Authorization

a. I certify that the foregoing information is correct.

Printed Name of Authorized Individual	Thomas O. Forslund
Title of Authorized Individual	Director
Date of Authorization	October 29, 2018

Chapter 35

Medicaid Benefit Recovery

Intent to Amend Rules

Statement of Reasons

The Wyoming Department of Health proposes to amend Chapter 35 pursuant to its statutory authority in Wyoming Statutes §§ 42-4-104 and 42-4-201 through -208.

Wyoming Statute § 42-4-201 through -208 mandates the Department of Health administer a third party liability program and an estate recovery program. This Amended Rule is promulgated in order to reduce the length of the rule, remove redundancies with Wyoming Statutes §§ 42-4-201 through -208, utilize plain language, remove definitions defined in Chapter 1, and no longer reference definitions that are not included in the substantive portion of the rule.

Further, this Amended Rule clarifies the definitions for "reasonable expenses incurred in preserving and disposing of the asset," "incentive allowance," and "legal title," as used for estate recovery purposes. Additionally, the Amended Rule clarifies the "undue hardship waiver" process outlined in Section 12.

Finally, the Wyoming Department of Health also proposes to promulgate changes to Chapter 35 to be compliant with the provisions of Wyoming Statutes §§ 14-2-1001 through -1008 for birthing costs pursuant to its statutory authority in Wyoming Statute § 42-4-122 and House Enrolled Act 59 (Medicaid Fairness Act), passed by the Legislature in the 2018 budget session.

As required by Wyoming Statutes § 16-3-103(a)(i)(G), this proposed rule change meets minimum substantive state statutory requirements.

CHAPTER 35
MEDICAID BENEFIT RECOVERY

Section 1. Authority. This Chapter is promulgated pursuant to the Wyoming Medical Assistance and Services Act at Wyoming Statute § 42-4-104(a)(iv).

Section 2. Purpose and Applicability.

(a) This Chapter shall apply to and govern all Medicaid third party liability and estate benefit recoveries.

(b) The requirements of Title V and Title XIX of the Social Security Act, 42 U.S.C. § 1396(a)(25), 42 U.S.C. § 1396K(a)(1)(A), 42 U.S.C. § 1396p, 42 C.F.R. Ch, IV §§ 433.135-433.154, 42 C.F.R. § 433.36, and the Wyoming Medicaid State Plan under Title XIX of the Social Security Act also apply to Medicaid herein.

Section 3. General Provisions.

(a) This Chapter is intended to implement and to be read in conjunction with W.S. §§ 42-4-114, 42-4-201 through 42-4-208, 42-4-122, 14-2-1001 through -14-2-1008, and applicable federal law.

Section 4. Definitions. Except as otherwise specified in Chapter 1 or as defined in this Section, the terminology used in this Chapter is the standard terminology and has the standard meaning used in accounting, health care, Medicaid, and Medicare.

(a) "Birth cost" - "Birth costs." As defined in W. S. § 14-2-1002(a)(i).

(b) "Bona fide effort to sell." The act of putting property up for sale and entering a written agreement with the Department.

(c) "Estate recovery." The recovery from the estate of a deceased client or from the estate of the spouse of a deceased client for reimbursement of Medicaid payments made on behalf of a client.

(d) "Incentive allowance." An allowance payment to the heirs, legatees or other person(s) who, having a valid claim to ownership of the deceased client's assets, who cooperate fully with the Department in maintaining and disposing of the assets so as to satisfy to the full extent possible the State's reimbursement right.

(e) "Medicaid benefit recovery." The recovery for reimbursement of Medicaid funds paid on behalf of a client.

(f) "Net proceeds." The dollar value from the sale of any real or personal property determined by deducting from the gross proceeds any amounts, including at a minimum, any liens or encumbrances against the property, realtor's commission fee, maintenance and repairs to the

home required by a property inspection or needed to sell the property, an appraisal or broker's price opinion, attorney's fees and costs, and closing costs.

(g) "Non-probate estate." That portion of a client's estate or the estate of the spouse of a client which is not administered pursuant to the Wyoming Probate Code.

(h) "Probate estate." That portion of a client's estate or the estate of the spouse of a client which is administered pursuant to the Wyoming Probate Code.

(i) "Reasonable expenses incurred preserving or disposing of the asset(s)." Reasonable expenses incurred either in maintaining or disposing of the assets of a client's estate distributed pursuant to the summary distribution provisions pursuant to the Wyoming Probate Code or distribution pursuant to an affidavit, including:

(i) Closing costs for the sale of real property which results in the partial or complete satisfaction of the Department's reimbursement right (closing costs include the reasonable attorney's fees of the seller, the cost of title insurance, and recording costs);

(ii) Costs of an Administration pursuant to W.S. § 2-1-301(viii) and probate administration pursuant to W.S § 2-7-802;

(iii) An incentive allowance as prescribed in Section 6 of this rule;

(iv) If Medicaid participates in a probate with a claim then it should not reduce its lien by the amount of the costs to sell the property;

(v) Property insurance premiums;

(vi) Real or personal property taxes;

(vii) Utility costs which are necessary to preserve the property, only allowed if the property is vacant or not payable by a renter or lessee pursuant to a rental or lease agreement;

(viii) Other costs incurred pursuant to a written property management agreement signed by the Department;

(ix) Expenses incurred in providing necessary maintenance or making necessary repairs, without which the salability of the property would be substantially impaired.

(A) Reasonable expenses do not include payment of credit card bills, telephone (cell phone) bills, or cable bills.

(j) "Third party payer." Any person, entity, agency, insurer, or government program that may be liable to pay, or that pays pursuant to an applicant's or client's right of recovery arising from an illness, injury, or disability for which Medicaid funds were paid or are obligated to be paid on behalf of the applicant or client. "Third party payer" includes, but is not limited to,

the following: Medicare; liability insurance carriers; medical payments coverage carriers; workers' compensation; persons or entities alleged to be liable by contract, tort, equity, or otherwise for the client's Medicaid reimbursable expenses for the illness, injury, or disability of the applicant or client; a spouse or parent of an applicant or client who is obligated by law or court order to pay all or part of such costs; a client's estate; health insurers; self-insured plans; group health plans; long-term care insurers; service benefit plans; managed care organizations; pharmacy benefit managers; and any other parties that are, by statute, contract, or agreement legally responsible for payment of claims for health care items or services for an applicant or client.

(k) "TPL waiver." A waiver granted by CMS of the third party liability requirements of this chapter.

Section 5. Assignment of Benefits and Third Party Liability.

(a) Assignment of Benefits, Third Party Liability, and Estate Recovery.

(i) By signing an application, an applicant shall be deemed to have made an assignment to the Department [the right to medical support or payment of medical expenses] on the applicant's behalf and on behalf of any relative, ward, or legal dependent for whom application is made.

(ii) The assignment of benefits is effective upon a determination of eligibility and remains in effect with respect to services provided during the period of eligibility for Medicaid, including any period of retroactive eligibility.

(b) Payer of last resort. Medicaid will pay for services only after payment of all other third party payers has been exhausted, except as provided by 42 U.S.C. § 1396d(b) and Title V of the Social Security Act.

(c) Recovery of payments from third party payers. If the Department pays or becomes obligated to pay Medicaid funds on behalf of an applicant or a client because of an injury, illness, or disability for which a third party is legally liable or obligated to pay, the Department may recover the full amount of such Medicaid funds from the third party to the extent of such party's liability up to the amount of medical assistance paid, as provided by law.

(d) Estate recoveries. If the Department pays or becomes obligated to pay Medicaid funds on behalf of a client who is fifty-five (55) years of age or older, or who was an inpatient in a nursing facility, intermediate care facility for people with intellectual disability or other medical institution, the Department may recover the full amount of such Medicaid funds from the estate of the deceased client or from the estate of a spouse.

(e) The Department, Division of Healthcare Financing, or its successor shall be named payee on all payments for Medicaid benefit recovery.

Section 6. Duties of Applicants and Clients.

(a) Notification of third party liability. An applicant or client shall notify the Social Security Administration or the Department of the possibility of third party liability at the time of application, at the time of an eligibility redetermination, and within ten (10) days after any event creating third party liability or any change in potential third party payers.

(b) Notice to providers. A client shall present the client's eligibility card to a provider at the time the client requests services. A client shall also inform a provider of the existence or possible existence of a third party payer at the time the client requests services from the provider and upon request from the provider.

(c) Cooperation in establishing paternity and obtaining medical support. As a condition of eligibility or continued eligibility, an applicant or client shall cooperate with the Department and local agency in establishing paternity of a child eligible for Medicaid or applying for Medicaid, and identifying and collecting from any third party payer. Cooperation includes:

(i) Appearing at the Department or local agency office to provide information or evidence regarding paternity;

(ii) Appearing as a witness at a court or other proceeding to testify regarding paternity;

(iii) Paying to the Department any medical support or medical payments received that are covered by the assignment of benefits;

(iv) Upon request from the Department or local agency, taking any other reasonable steps to assist in establishing paternity, determining third party liability and securing payment from third party payers; and

(v) Cooperating with the Department and the Department of Family Services in establishing paternity for applicable Medicaid births for the purposes of recovery of birth cost pursuant to W.S. §§ 42-4-122 and 14-2-1001 through 14-2-1008. Pursuant to W.S. §14-2-1003, not more than sixty (60) days after an unmarried client of Medicaid gives birth to a child, the Department shall notify the Department of Family Services of the total birth cost. Total birth cost shall include:

(A) Maternity related expenditures including prenatal and postpartum care from nine (9) months prior to delivery through two (2) months after delivery, but not to exceed the average birth cost paid by Wyoming Medicaid.

(d) The refusal to cooperate in establishing paternity as set forth above, or the refusal to cooperate in locating third party payers or recovering payments from such payers, shall render such person ineligible for Medicaid, except as provided in 42 C.F.R. § 433.147 and 433.148.

(e) Incentive allowance for Estate Recovery.

(i) The Department may allow an incentive payment to the heirs, legatees or other person(s), when the following conditions are met:

(A) An incentive allowance shall be the lesser of ten percent (10%) of the net proceeds from the sale of the asset(s), or two-thousand ($2,000.00) dollars:

(B) An incentive allowance shall be permitted only upon approval in writing by the Department or their designee, and only if the Medicaid benefits paid on behalf of the client exceeds the net proceeds; and

(C) The net proceeds from the sale shall be determined by deducting from the sale price the costs of discharging any encumbrances on the property and other reasonable expenses incurred preserving or disposing of the asset(s).

(f) If a Medicaid client is enrolled with a private health insurer, the client must follow the rules of the primary insurance, including using an in-network provider.

Section 7. Duties of Providers.

(a) Verify and obtain information. At the time a client requests services from a provider, the provider shall review the client's eligibility card for information regarding third party payers. The provider shall ask the client if the information on the card is current and whether there are or may be additional third party payers. If the provider learns of a potential third party payer that is not listed on the eligibility card, the provider shall notify the Department in writing of that information within thirty (30) calendar days.

(b) Notify the Department of requests for information. Release of information by providers for casualty related third party resources not known to the State may be identified through requests for medical reports and bills received by providers from attorneys, insurance companies, and other parties. Providers shall contact the Department before responding to such requests.

(c) Notification of death.

(i) An institutional provider shall notify the Department, in writing, of any client's death which occurs in the facility or which occurs after the client is transported from the provider's facility to another facility, such as a hospital or hospice.

(ii) Time of notice. The notification shall be sent to the Department on or before the end of the third working day after the client's death.

(iii) Contents of notice. The notification shall be in the form and contain the information required by the Department, as specified in the Provider Manual.

(d) Billing. Unless otherwise provided by a TPL waiver, this subsection shall govern the submission of bills involving third party payers.

(i) When a provider is informed that the client has or may have coverage by a third party payer, the provider shall seek payment from the third party payer prior to submitting a Medicaid claim. When the amount payable by the third party payer is less than the allowable Medicaid payment, the provider may submit a Medicaid claim for the difference. The Medicaid claim shall be accompanied by documentation of the amount payable by the third party payer or submitted electronically with the appropriate coordination of benefits information, including claims adjustment reason and remark codes.

(ii) If a third party payer rejects the request for payment, the provider may submit a Medicaid claim to the Department. The provider shall attach a copy of the notice of rejection to the Medicaid claim, upload a copy of the notice of rejection to the Medicaid web portal to be linked to the corresponding electronic claim, or submit the Medicaid claim electronically with the appropriate coordination of benefits information, including claims adjustment reason and remark codes.

(iii) If a provider has not received payment or a rejection notice from a third party payer within ninety (90) days after submitting two (2) requests or attempts for payment, the provider may submit a Medicaid claim. The provider shall submit with the Medicaid claim, copies of the requests for payment to the third party payer, and any written communication the provider has received from the third party payer.

(iv) A provider which has received payment from a third party payer may submit a Medicaid claim. In such cases the provider shall submit with the Medicaid claim documentation of the payment received. The Department shall allow the Medicaid claim only to the extent the allowable Medicaid reimbursement exceeds the payment received from the third party payer and subject to the Department's normal procedures and standards.

(v) A provider shall submit Medicaid claims to the Department within twelve (12) months of the date of service or discharge, whichever is later, regardless of the potential involvement of a third party payer, except that Medicare crossover claims shall be submitted within six (6) months after the date of payment or rejection by Medicare. Medicaid claims submitted after the time limits specified in this paragraph shall be rejected. Refer to Chapter 3 of the Medicaid rules for further information.

(vi) For the purposes of paragraph (d)(i) of this section, any amount paid by Medicaid when combined with the amount paid by the third party payer, shall not exceed the amount payable to the provider under any preferred provider or similar agreement between the provider and that third party payer. The Department is only responsible for the patient's responsibility.

(vii) A provider shall not opt-out of participation with a third party payer. If a provider chooses to opt-out of participation with a third party payer, the Department shall not pay

for services covered by, but not billed to, the third party payer. The provider shall work with the third party payer or client to have the claim submitted to the carrier.

(viii) If a provider chooses to bill Wyoming Medicaid, the provider accepts Medicaid payment as payment in full. The provider shall not bill Wyoming Medicaid and accept payment and bill the other third party. The provider shall choose whether to bill Wyoming Medicaid or bill the other party and wait for legal liability to be established.

Section 8. Payment or Rejection of Medicaid Claims Subject to Third Party Liability.

(a) Probable existence of liability of third party payer established at time of Medicaid claim. If the Department has established the probable existence of liability of a third party payer at the time a provider submits a Medicaid claim, the Department shall reject the Medicaid claim and return it to the provider for a determination of the amount of such liability.

(b) Establishing probable existence of liability of a third party payer. The probable existence of liability of a third party payer is established when the Department receives information from any source confirming the existence and extent of liability of a third party payer. When the amount of liability is established, the Department shall process and pay Medicaid claims involving third party liability only to the extent that the Medicaid payment allowed by the Department's normal procedures and standards exceeds the amount of the third party payer's liability.

(c) Unavailability of third party payments. Third party payments are not available at the time of the submission of a Medicaid claim if the existence and extent of third party payer liability is still disputed. If third party payments are not available, the Department shall process Medicaid claims subject to its normal procedures.

(d) Reconsideration. A provider may request that the Department reconsider a decision to recover payments because of third party liability. Such request shall be made and shall be handled pursuant to the reconsideration provisions as set forth in Chapter 3, Section 14, of the Wyoming Medicaid Rules.

(e) Denial of improper claims. The Department shall deny claims which are improperly submitted or which contain errors of any kind. Denied claims may be resubmitted, subject to applicable federal and state requirements, including Chapter 1 and Chapter 16.

Section 9. Duties of Attorneys.

(a) Attorneys shall be obligated to cooperate with the Department to recover under this Section in accordance with W.S. §§ 42-4-201 through 42-4-208.

(b) An attorney representing a Medicaid client shall not disburse any insurance proceeds to the Medicaid client or retain any portion as attorney's fees prior to submitting a statement of net recovery distribution and payment to the Department.

Section 10. Medicaid Third Party Liability Recovery.

(a) The Department may not agree to a settlement which involves the compromise or release of any portion of the federal medical assistance percentage, except as allowed by federal law.

(b) Amount of the Department's recovery. The Department may recover from any settlement or judgment involving a third party payer the full amount of Medicaid funds paid or to be paid on behalf of the client because of the injury, illness, or disability for which such payments were made.

(i) If the Department does not file an independent action or intervene in an existing action, the Department shall calculate its reduced lien by deducting:

(A) Thirty-three percent (33%) for attorney's fees; and

(B) A proportionate share of the reasonable attorney's costs incurred in obtaining the client's recovery.

(I) The Department's proportionate share of the reasonable costs incurred in making the client's recovery shall be determined by:

(1.) Dividing the amount of the Department's recovery (the amount of Medicaid benefits reimbursed minus attorney's fees as provided in this Section) by the amount of the client's gross recovery; and

(2.) Multiplying the determined fraction by the reasonable costs incurred in making the recovery.

(II) For purposes of this section, "the reasonable attorney's costs incurred in making the client's recovery" shall be court costs, costs of litigation, travel costs, expert witness fees, deposition expenses, and any other costs necessarily incurred in making the recovery. Reasonable costs shall be in the sole discretion of the Department and shall not include any items for which the client is not also responsible.

(ii) The Department may consider the cost-effectiveness of reducing its claim for reimbursement after evaluating all relevant factors, including:

(A) Available insurance coverage or other factors relating to the assets or solvency of the liable third party;

(B) Factual and legal issues pertaining to liability;

(C) Legal issues or restrictions on the Department's recovery, including problems of proof affecting the ability to obtain settlement or judgment and;

(D) Estimated fees and costs associated with the Department pursuing its claim.

(c) Structured settlements. A client's recovery shall not be placed in a structured settlement until the Department has been reimbursed and issued a release of its reimbursement right. If a client prematurely enters into a structured settlement under which the initial payment to the client is insufficient to reimburse the Department, the client shall pay the Department all funds received in each installment until the Department is paid in full. All structured settlements shall fully comply with the requirements pertaining to annuities under the Department's rules.

(d) Future Medicaid payments. Except as otherwise agreed, the settlement of a client's claim does not preclude the Department from seeking Medicaid benefit recovery for Medicaid payments made after the date of such settlement.

(e) The Department shall have the right to recover directly from a third party payer to the extent of Medicaid funds paid or to be paid on behalf of a client when the existence and extent of liability of such third party payer is established. In situations where a Medicaid client was not represented by legal counsel, an attorney representing an insurance company shall not disburse any insurance proceeds to the Medicaid client prior to submitting a statement of available proceeds (declaration sheet), payment to the Department, and approval by the Department.

(f) The Department shall have the right to recover from any attorney who knowingly fails to notify the Department of any settlement of judgment or fails to ensure the Department is reimbursed to the extent of its reimbursement right.

(g) The Department shall have the right to recover directly from a provider which has received Medicaid funds paid on behalf of a client to the extent the provider has received payments from a third party payer for the same services.

(h) The Department shall have the right to recover from any attorney who knowingly fails to notify the Department of any settlement or judgment or fails to ensure the Department is reimbursed to the extent of its reimbursement right.

Section 11. Estate Recoveries.

(a) Pursuant to W.S. § 42-4-207(c), the Department may impose a pre-death lien against a client's real property:

(i) If the client is an inpatient in a nursing facility, intermediate care facility for people with intellectual disability, or other medical institution; and the client cannot reasonably be expected to be discharged from the facility and return home; or

(ii) If the client has been institutionalized for ninety (90) days or longer without a discharge plan, it is presumed that the client will not be discharged and return home; however,

an applicant or the client will be provided with a notice of their right to a hearing prior to a determination being made that the applicant or the client is permanently institutionalized.

(b) Pursuant to W.S. § 42-4-207(j), the Department may impose a lien upon property of any estate, as defined in W.S. § 42-4-206(g), of a deceased client for the amount of medical assistance provided while the client was fifty-five (55) years of age or older or while the client was an inpatient in a nursing facility, intermediate care facility for people with intellectual disability or other medical institution. The lien may be imposed regardless of the presence in the home of individuals identified in W.S. § 42-4-207(e).

(i) For estate recovery purposes, the Department defines "legal title" for real property in W.S. § 42-4-206(g) to mean title of record in the county public property records.

(c) If the client has purchased a long-term care partnership certified policy, the Department shall take into consideration the benefits paid by the policy in determining the extent of estate recovery.

(d) The Department may recover against a lien imposed under W.S. § 42-4-207 only after the death of the client's surviving spouse, if any, and:

(i) If the client has no surviving child who is under age twenty-one (21), or is blind, or permanently and totally disabled.

(e) A claim filed pursuant to W.S. § 42-4-206(a) against the surviving spouse's estate, is limited to the value of the assets of the estate determined to exist at the time of death of the surviving spouse that were marital property or jointly owned property at any time during the marriage.

(f) The Department may foreclose its lien outside the probate action pursuant to W.S. §§ 2-7-717.

(g) Procedures for recovery from non-probate estate.

(i) The Department shall have the right to recover from non-probate assets pursuant to W.S. §§ 42-4-206 or 207, and shall have the discretion to decide how to proceed.

(ii) The Department shall have the right to recover directly from a transferee or other individual or entity which has possession, control, or ownership of property received from the non-probate estate of a deceased client.

(h) Any lien or claim against the estate or assets of a client age fifty-five (55) years or older when receiving medical assistance or an inpatient in a facility, intermediate care facility for people with intellectual disability or other medical institution shall be limited to amounts expended for nursing facility services, home and community-based services including waiver services, related hospital and prescription drug services, and any items or services under the State Plan.

(i) Reasonable expenses incurred in preserving or disposing of the assets are only allowed if:

(i) They are documented with specificity and by an itemized statement or ledger of expenses with copies of receipts,

(ii) They are paid by someone other than the client (use of the client's personal funds will not be reimbursable), and

(iii) They were paid after one of the following events occurred:

(A) Client entered a nursing facility, an assisted living facility, an intermediate care facility for people with intellectual disability, or other medical institution, never returned home, and failed to pay the expenses; or

(B) Client passed away.

(j) The Department may decline to pursue an estate recovery if it determines that it is not cost-effective to recover.

(k) Bona Fide Efforts to Sell. The Department may enter into a stipulation and consent agreement with Medicaid client(s), heirs, or legatees when the following conditions are met:

(i) The client has received Medicaid for a period of at least six (6) months;

(ii) Net proceeds shall be paid to the Department to reimburse medical payments made on behalf of the client;

(iii) The property shall be actively placed on the market;

(iv) The property shall not be sold for less than eighty percent (80%) of fair market value, unless the Department provides approval of the sale of the property for less than eighty percent (80%) of its value; and

(v) If the net proceeds exceed the amount of the Medicaid benefits paid, Medicaid will receive payment in full for the benefits and services provided to the Medicaid client(s) and eligibility for benefits shall be redetermined.

Section 12. Undue Hardship Waiver.

(a) Notice of right to request undue hardship waiver. At the time the Department imposes a lien or files a probate claim, it shall provide written notice by mail to the personal representative or known heirs of the right to request an undue hardship waiver.

(b) Request for undue hardship waiver.

(i) Any individual who receives notice pursuant to subsection (a) may request an undue hardship waiver.

(ii) A request for an undue hardship waiver shall be mailed to the Department by certified mail, return receipt requested, within thirty-three (33) days of the date of the Department's notice pursuant to subsection (a). The request shall include documentation that the decedent's home is part of the estate, that the decedent's home is part of a business, including a working farm or ranch, show that recovery of the home would result in the heirs or beneficiaries losing their means of making a living, and provide other relevant documentation upon the Department's request. The failure to provide the information required by this paragraph with the request shall result in the dismissal with prejudice of the undue hardship waiver request.

(c) Consideration of request. Within thirty (30) days of receipt of a request for an undue hardship waiver, the Department shall consider whether the information furnished shows an undue hardship. During the thirty (30) days of review, the Department may request additional information before making a final decision. The request shall be made in writing by certified mail, return receipt requested. The party to whom the request is directed shall provide the requested information within thirty (30) days after the receipt of the certified mail. The Department shall have fifteen (15) days from receipt of the additional information to make a decision. Failure to provide the requested information shall result in a denial of the request. The Department's decision shall be in writing, and shall be delivered by certified mail, return receipt requested. If the request is denied, the Department shall provide notice of the opportunity to request that the Department reconsider the decision.

(d) Reconsideration. A party may request that the Department reconsider a decision to deny an undue hardship waiver. Such request shall be made and shall be handled pursuant to the reconsideration provisions as set forth in Chapter 3, Section 14, of the Wyoming Medicaid Rules. A party may submit any additional relevant information at the time of the request. A party that fails to request reconsideration pursuant to this section may not subsequently request an administrative hearing pursuant to Chapter 4 regarding the adverse action.

(e) Administrative Hearing. If an administrative hearing is requested, it shall be conducted in accordance with Wyoming Medicaid Rules, Chapter 4, Medicaid Administrative Hearings, except the burden of proof in subsection (f) applies to this Chapter.

(f) Burden of proof. If an administrative hearing is requested, it shall be conducted in accordance with the Wyoming Medicaid Rules, Chapter 4, Medicaid Administrative Hearings, except the burden of proof in subsection (f) applies to this Chapter.

Section 13. Incorporation by Reference.

(a) For any code, standard, rule, or regulation incorporated by reference in this rules:

(i) The Department has determined that incorporation of the full text in these rules would be cumbersome or inefficient given the length or nature of the rules:

(ii) The incorporation by reference does not include any later amendments or editions of the incorporated matter beyond the applicable date identified in subsection (b) of this section; and

(iii) The incorporated code, standard, rule, or regulation is maintained at the Department and is available for public inspection and copying at cost at the same location.

(b) Each rule or regulation incorporated by reference in these rules is further identified as follows:

(i) Referenced in Section 2 and 5 is Title V of the Social Security Act, which is incorporated as the effective date of this Chapter and can be found at http://ssa.gov.

(ii) Referenced in Section 2 is Title XII of the Social Security Act, including 42 U.S.C. §§ 1396a(25), 1396k(a)(1)(A), and 1396p, which is incorporated as of the effective date of this Chapter and can be found at http://ssa.gov.

(iii) Referenced in Section 2 is 42 C.F.R. §§ 433.135 through 433.154, which is incorporated as of the effective date of this Chapter and can be found at http://www.ecfr.gov.

(iv) Referenced in Section 2 is 42 C.F.R. § 433.36, which is incorporated as of the effective date of this Chapter and can be found at http://www.ecfr.gov.

(v) Referenced in Section 2 is the Wyoming Medicaid State Plan, which is incorporated as of the effective date of this Chapter and can be found at https://health.wyo.gov/healthcarefin/medicaid/spa/.

(vi) Referenced in Section 5 is 42 U.S.C. § 1396d(b), which is incorporated as of the effective date of this Chapter and can be found at http://ssa.gov.

(vii) Referenced in Section 6 is 42 C.F.R. § 433.148(b), which is incorporated as of the effective date of this Chapter and can be found at http://www.ecfr.gov.

(viii) Institutional Provider Manual at wymedicaid.portal.conduent.com/manuals, go to provider, select provider manuals and bulletins, choose institutional manual, and go to Medicaid Death Report Form.

CHAPTER 35
MEDICAID BENEFIT RECOVERY

Section 1. Authority. This ~~rule~~Chapter is promulgated ~~by the Department of Health~~ pursuant to the Wyoming Medical Assistance and Services Act at ~~W.S.~~Wyoming Statute § 42-4-~~101~~104(a)(iv~~)~~ ~~*et seq*~~.

Section 2. Purpose and Applicability.

(a) This ~~c~~Chapter shall apply to and govern all ~~issues of~~ Medicaid third party liability and estate benefit recoveries. ~~This Chapter shall become effective upon signature of the Governor, and filing with the Secretary of State.~~

(b) ~~The Department may issue manuals or bulletins to providers, and other affected third parties to interpret the provisions of this Chapter. Such manuals or bulletins shall be consistent with and reflect the policies contained in this Chapter. The provisions contained in manuals or bulletins shall be subordinate to the provisions of the rules and regulations.~~The requirements of Title V and Title XIX of the Social Security Act, 42 U.S.C. § 1396(a)(25), 42 U.S.C. § 1396K(a)(1)(A), 42 U.S.C. § 1396p, 42 C.F.R. Ch, IV §§ 433.135-433.154, 42 C.F.R. § 433.36, and the Wyoming Medicaid State Plan under Title XIX of the Social Security Act also apply to Medicaid ~~and are incorporated by this reference as of the effective date of this Chapter, and may be cross-referenced throughout this Chapter where applicable. The incorporation by reference does not include any later amendments or editions of the incorporated matter~~ herein.

Section 3. General Provisions.

(a) This Chapter is intended to implement and to be read in conjunction with W.S. §§ 42-4-114, 42-4-201 through 42-4-208, 42-4-122, ~~and~~ 14-2-1001 through -14-2-1008, and applicable federal law~~;~~. ~~including OBRA '90 and OBRA '93.~~

~~(b) Terminology. Except as otherwise specified, the terminology used in this Chapter is the standard terminology and has the standard meaning used in accounting, health care, Medicaid and Medicare.~~

~~(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, including any applicable amendments, corrections, or revisions.~~

Section 4. Definitions. ~~The following definitions shall apply in the interpretation and enforcement of these rules. Where the context in which words are used in these rules indicates that such is the intent, words in the singular number shall include the plural and vice versa. Throughout these rules gender pronouns are used interchangeably. The drafters have attempted to utilize each gender pronoun in equal numbers, in random distribution. Words in each gender include individuals of the other gender.~~ Except as otherwise specified in Chapter 1 or as defined in this Section, the terminology used in this Chapter is the standard terminology and has the standard

meaning used in accounting, health care, Medicaid, and Medicare.~~For the purpose of these rules, the following shall apply:~~

~~(a) "Adverse action." "Adverse action" as defined in Chapter 1, which definition is incorporated by this reference. "Adverse action" shall not include the Department's decision about whether and/or how to recover pursuant to Section 8.~~

~~(b) "Annuity." As annuity is defined as a contract or agreement by which one receives fixed, non-variable payments on an investment for a lifetime or a specified number of years. An annuity containing a balloon payment (or lump sum payment) will be considered an available resource. A commercial (non-employment related) annuity purchased by or for an individual using that individuals assets will be considered an available resource unless it meets the following criteria. The annuity:~~

~~(i) Is irrevocable;~~

~~(ii) Pays out principal and interest in equal monthly installments (no balloon payment) to the individual in sufficient amounts that the principal is paid out within the actuarial life expectancy of the individual as published by the Centers for Medicare & Medicaid Services (CMS). The average number of years of expected life remaining for the individual must equal or exceed the stated life of the annuity;~~

~~(iii) Names the State of Wyoming, Department of Health, Office of Medicaid as the residual beneficiary of funds remaining in the annuity, not to exceed any Medicaid funds expended on the individual during his lifetime; and~~

~~(iv) Is issued by an insurance company licensed and approved to do business in the State of Wyoming.~~

~~If the individual is not reasonably expected to live longer than the guarantee period of the annuity, the individual will not receive fair market value for the annuity based on the projected return. In this case, the annuity is not actuarially sound and a transfer of assets for less than fair market value has taken place. This will subject the individual to a penalty which is assessed based on a transfer of assets for less than fair market value that occurred at the time the annuity was purchased.~~

~~(c) "Applicant." A person who has submitted a written application for Medicaid, either directly or through a representative acting on his or her behalf, which has not received final action.~~

~~(d) "Application." An applicant's written request for Medicaid.~~

~~(e) "Assets." "Assets" as defined by W.S. 42-2-401(a)(1).~~

~~(f) "Assignment of benefits." The transfer from an applicant or recipient to the Department of the applicant's or recipient's rights, or the rights of another, to medical support or payments for services from any third party payer.~~

~~(g) "Attorney General." The Attorney General of the State of Wyoming, his agent, designee or successor.~~

(~~h~~a) "Birth cost" - "Birth costs." As defined in W.S. § 14-2-1002(a)(i).

(~~i~~b) "Bona fide effort to sell." The act of putting property up for sale and entering a written agreement with the Department.

~~(j) "Certified mail, return receipt requested." Certified mail, return receipt requested as provided by the United States Postal Service, or delivery via a commercial delivery service which provides tracking of the communication and written documentation of its delivery. "Certified mail, return receipt requested" does not include communication by facsimile transmission, telephone, or e-mail.~~

~~(k) "Chapter 1." Chapter 1, Rules for Medicaid Administrative Hearings, of the Wyoming Medicaid Rules.~~

~~(l) "Chapter 3." Chapter 3, Provider Participation, of the Wyoming Medicaid Rules.~~

~~(m) "Claim." A request by a provider for Medicaid payment for services provided to a recipient.~~

~~(n) "CMS." The Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services, its agent, designee or successor.~~

~~(o) "Contract attorney." A lawyer or law firm which has entered into a contract with the Department to assist in Medicaid benefit recovery, whether third party liability reimbursement or estate recovery, or both. Unless otherwise specified by the contract, a contract attorney shall be authorized to represent the Department in all matters related to the enforcement of the Department's reimbursement rights pertaining to Medicaid benefit recovery, whether third party liability reimbursement or estate recovery.~~

~~(p) "Cost-effective." The determination by the Department that the expected expenses of a recovery, including, but not limited to, administrative costs, attorney's fees, court costs, costs of litigation, travel costs, expert fees and deposition expenses, are less than the expected amount of the recovery.~~

~~(q) "Costs." Reasonable out-of-pocket costs incurred by an attorney in the prosecution of a right of recovery, including, but not limited to, court costs, costs of litigation, travel costs, expert witness fees and deposition expenses.~~

~~(r) "Department." The Wyoming Department of Health, its agent, designee or successor.~~

~~(s) "DFS." The Wyoming Department of Family Services, its agent, designee or successor.~~

~~(t) "Director." The Director of the Department of Health, the director's agent, designee or successor.~~

~~(u) "Estate." "Estate" as defined by W.S. 42-4-206(g)(ii), which is incorporated by this reference.~~

(~~v~~c) "Estate recovery." The recovery ~~under W.S. 42-4-206 and 42-4-207~~ from the estate of a deceased ~~recipient~~client or from the estate of the spouse of a deceased ~~recipient~~client for reimbursement of Medicaid payments made on behalf of a ~~recipient~~client.

~~(w) "Home." A recipient's primary residence at the time the recipient enters an institution.~~

~~(x) "HHS." The United States Department of Health and Human Services, its agent, designee or successor.~~

(~~y~~d) "Incentive allowance." An allowance payment to the heirs, legatees or other person(s) ~~with a~~ who, having a valid claim to ownership of the deceased ~~recipient's~~client's assets~~, who obtain title to the assets and~~ who cooperate fully with the Department ~~and/or its contract attorneys~~ in maintaining and disposing of the assets so as to satisfy to the full extent possible the State's reimbursement right.

~~(i) An incentive allowance shall be the lesser of ten percent (10%) of the net proceeds from the sale of the asset(s), except that in no case shall an incentive allowance exceed a total of two thousand ($2,000.00) dollars;~~

~~(ii) An incentive allowance shall be permitted only upon written agreement with the Department and/or its contract attorneys, and only if the Medicaid benefits paid on behalf of the recipient exceed the value of the assets sold; and~~

~~(iii) The net proceeds from the sale shall be determined by deducting from the sale price the costs of discharging any encumbrances on the property and other reasonable expenses incurred in maintaining or disposing of the asset(s).~~

~~(z) "Institution." A hospital, nursing facility, intermediate care facility for the mentally retarded (ICF/MR) or any other provider which is an "institution" as defined by 42 C.F.R. 435.1009, which definition is incorporated by this reference.~~

~~(aa) "Institutional provider." An institution which is a Medicaid provider.~~

(~~bb~~) ~~"Lien~~ recovery~~." With respect to the property of a recipient, probate recoveries, or~~and ~~non-probate recoveries, the Department's right to recover pursuant to W.S. § 42-4-207(b), (c), or (j), from the recipient, the estate of a deceased recipient, or the estate of the spouse of a~~

~~deceased recipientt for Medicaid payments made on behalf of the recipient or the deceased recipien. With respect to third-party liability recovery, the Department's right to recover pursuant to W.S. 42-4-202.~~

~~(cc) "Medicaid." Medical assistance and services provided pursuant to Title XIX of the Social Security Act as amended, and/or the Wyoming Medical Assistance and Services Act, as amended. "Medicaid" includes any successor or replacement program enacted by Congress or the Wyoming Legislature.~~

(~~dd~~e) "Medicaid benefit recovery." The recovery ~~under W.S. 42-4-201 through 42-4-207~~ for reimbursement of Medicaid funds paid on behalf of a ~~recipient~~client.

~~(ee) "Medicare." The health insurance program for the aged and disabled established pursuant to Title XVIII of the Social Security Act.~~

~~(ff) "Medicare crossover claim." A claim for services provided to a recipient who is eligible for Medicare and Medicaid.~~

(f) "Net proceeds." The dollar value from the sale of any real or personal property determined by deducting from the gross proceeds any amounts, including at a minimum, any liens or encumbrances against the property, realtor's commission fee, maintenance and repairs to the home required by a property inspection or needed to sell the property, an appraisal or broker's price opinion, attorney's fees and costs, and closing costs.

(~~ggg~~) "Non-probate estate." That portion of a ~~recipient's~~client's estate or the estate of the spouse of a ~~recipient~~client which is not administered pursuant to the Wyoming Probate Code.

~~(hh) "OBRA '90." The Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508.~~

~~(ii) OBRA '93." The Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66.~~

(~~jj~~h) "Probate estate." That portion of a ~~recipient's~~client's estate or the estate of the spouse of a ~~recipient~~client which is administered pursuant to the Wyoming Probate Code.

~~(jj) "Provider." A provider as defined by Chapter 3, which definition is incorporated by this reference.~~

(~~kk~~i) "Reasonable expenses incurred preserving or disposing of the asset(s)." ~~The following~~Reasonable expenses incurred either in maintaining or disposing of the assets of a ~~recipient's~~client's estate distributed pursuant to the summary distributions provisions ~~of W.S. 2-1-201 through 2-1-205:~~pursuant to the Wyoming Probate Code or distribution pursuant to an affidavit, including:

(i) Closing costs for the sale of real property which results in the partial or complete satisfaction of the Department's reimbursement right (closing costs include the reasonable attorney's fees of the seller, the cost of title insurance, and recording costs);

(ii) Costs of an Administration pursuant to W.S. § 2-1-301(viii) and ~~summary probate pursuant to W.S. § 2-1-204~~probate administration pursuant to W.S. § 2-7-802;

(iii) An incentive allowance as prescribed in Section 6 of this rule~~;~~

(iv) If Medicaid participates in a probate with a claim then it should not reduce its lien by the amount of the costs to sell the property;

(v) Property insurance premiums;

(vi) Real or personal ~~P~~property taxes; ~~(real and/or personal); and~~

(vii) Utility costs which are necessary to preserve the property, only allowed if the property is vacant or not payable by a renter or lessee pursuant to a rental or lease agreement~~.~~;

(viii) Other costs incurred pursuant to a written property management agreement signed by the Department;

(ix) Expenses incurred in providing necessary maintenance or making necessary repairs, without which the salability of the property would be substantially impaired.~~;~~ ~~and~~

(A) Reasonable expenses do not include payment of credit card bills, telephone (cell phone) bills, or cable bills.

~~(viii) Reasonable expenses are only allowed if:~~

~~(A) Must be documented and must have been paid after the recipient entered a nursing facility; and~~

~~(B) Shall not be allowable for any time during which another individual was residing in the home.~~

~~(mm) "Recipient." A person who has been determined eligible for Medicaid.~~

~~(nn) "Recipient's gross recovery." The total present value of a judgment or settlement arising out of a right of recovery.~~

~~(oo) "Right of recovery." The right or potential right of a recipient, or someone acting on behalf of a recipient, to recover from a third party payer.~~

~~(pp) "Right of reimbursement" or "reimbursement right." The Department's right to recover pursuant to this Chapter for Medicaid benefits paid on behalf of a recipient. The right may be asserted and enforced by any means permitted by law to recover a debt.~~

~~(qq) "Rules governing contingent fees." The Rules Governing Contingent Fees for Members of the Wyoming State Bar, as promulgated by the Supreme Court, State of Wyoming.~~

~~(rr) "Services." Goods or services authorized for Medicaid payments under applicable federal law, W.S. 42-4-103 and the rules of the Department.~~

~~(ss) "Settlement." An agreement under which a third party payer agrees to make payment to a recipient or third party for an illness, injury, or disability which has required services for which the Department has made or is or becomes obligated to make Medicaid payments on behalf of the recipient.~~

~~(tt) "Structured settlement." A settlement under which more than one payment of money or benefits will be made. "Structured settlement" includes any payment schemes with more than one payment, regardless of the number of payments, the amount of the payments, the periodicity of the payments or the reason for the payments.~~

~~(uu) "Subrogation." The succession of the Department to the rights of a recipient with respect to third party payers.~~

~~(vv) "Third party liability." The right of a recipient to recover from a third party payer the costs of Medicaid services furnished to the recipient.~~

(~~ww~~j) "Third party payer." An<u>y</u> person, entity, agency, insurer, or government program that may be liable to pay, or that pays pursuant to an ~~recipient's~~<u>applicant's or client's</u> right of recovery arising from an illness, injury, or disability for which Medicaid funds were paid or are obligated to be paid on behalf of the ~~recipient~~<u>applicant or client</u>. "Third party payer" includes, but is not limited to, <u>the following:</u> Medicare~~,~~<u>;</u> ~~insurance companies,~~<u>liability insurance carriers; medical payments coverage carriers;</u> workers' compensation~~,~~<u>;</u> persons or entities ~~or others~~ alleged to be ~~contractually, tortuously, equitably, or otherwise legally liable~~ <u>liable by contract, tort, equity, or otherwise for the client's Medicaid reimbursable expenses</u> for ~~injury to a recipient~~<u>the illness, injury, or disability of the applicant or client;</u> ~~for which Medicaid provides services to the recipient,~~<u>;</u> a spouse or parent <u>of an applicant or client</u> who is obligated by law or court order to pay all or part of such costs~~,~~<u>;</u> ~~or~~ a ~~recipient's~~<u>client's</u> estate~~.~~<u>; health insurers; self-insured plans; group health plans; long-term care insurers; service benefit plans; managed care organizations; pharmacy benefit managers; and any other parties that are, by statute, contract, or agreement legally responsible for payment of claims for health care items or services for an applicant or client.</u> ~~"Third party payer" also includes an individual or entity liable pursuant to this Chapter.~~

(<u>xxk</u>) "TPL waiver." A waiver granted by CMS of the third party liability requirements of this chapter.

~~(yy) "Undue hardship." An undue hardship exists if the decedent's home is part of the estate and that home is part of a business, including a working farm or ranch, and recovery of the home would result in the heirs or beneficiaries losing their means of making a living. "Undue hardship" includes any additional definition promulgated by HHS as mandatory administrative regulation, but does not include any portion of any additional definition that is optional unless the optional portion is specifically adopted in the State Plan. Any part of this definition that is inconsistent with a mandatory provision in HHS's definition shall become inoperative.~~

~~(zz) "Working day." Monday through Friday, exclusive of State holidays.~~

Section 5. Assignment of ~~b~~Benefits and ~~t~~Third ~~p~~Party ~~l~~Liability.

(a) Assignment of Benefits, Third Party Liability, and Estate Recovery.

(i) ~~Automatic assignment of benefits.~~ By signing an application, an applicant ~~makes~~ shall be deemed to have made an assignment ~~of benefits~~ to the Department [the right to medical support or payment of medical expenses] on the applicant's behalf and on behalf of any relative, ward, or legal dependent for whom application is made.

(ii) ~~Effective dates of assignment of benefits.~~ The assignment of benefits is effective upon a determination of eligibility and remains in effect with respect to services provided during the period of eligibility for Medicaid, including any period of retroactive eligibility.

(b) Payer of last resort. Medicaid will pay for services only after ~~all sources of~~ payment of all other third party ~~liability have~~ payers has been exhausted, except as provided by 42 U.S.C. § 1396d(b) and Title V of the Social Security Act.

(c) Recovery of payments from third party payers. If the Department pays or ~~is or~~ becomes obligated to pay Medicaid funds on behalf of an applicant or a ~~recipient~~client because of an injury, illness, or disability for which a third party ~~payer~~ is legally liable~~,~~ or obligated to pay, the Department may recover the full amount of such Medicaid funds from the third party ~~payer~~ to the extent of such ~~payer's~~ party's liability~~, to the recipient~~up to the amount of medical assistance paid, as provided by law.

(d) Estate recoveries. If the Department pays or ~~is or~~ becomes obligated to pay Medicaid funds on behalf of a ~~recipient~~client who is fifty-five (55) years of age or older, or who was an inpatient in a nursing facility, intermediate care facility for ~~the mentally retarded~~people with intellectual disability or other medical institution, the Department may recover the full amount of such Medicaid funds from the estate of the deceased ~~recipient~~client or from the estate of a spouse.

(e) The Department, Division of Healthcare Financing, or its successor shall be named payee on all ~~checks, drafts, or other~~ payments ~~made to the Department~~ for Medicaid benefit recovery.

~~(f) Liability to the Department.~~

~~(i) A person, including a third-party payer, must make the attorney general, representing the director of the Department, a party in all negotiations for settlement, compromise or release.~~

~~(ii) A person, including a third-party payer, remains liable to the State's reimbursement right unless before paying a settlement the person obtains a signed release from the attorney general.~~

Section 6. Duties of Applicants and ~~Recipients~~Clients.

(a) Notification of third party ~~payer~~liability. An applicant or ~~recipient~~client shall notify ~~the local agency or~~ the Social Security Administration or the Department of the possibility of third party liability at the time of application, at the time of an eligibility redetermination, and within ten (10) days after any event creating third party liability or any change in potential third party payers.

(b) Notice to providers. A ~~recipient~~client shall present ~~his or her~~ the client's eligibility card to a provider at the time the ~~recipient~~client requests services. A ~~recipient~~client shall also inform a provider of the existence or possible existence of a third party payer at the time the ~~recipient~~ client requests services from the provider and upon request from the provider.

(c) Cooperation in establishing paternity and obtaining medical support. As a condition of eligibility or continued eligibility, a~~A~~n applicant or ~~recipient~~client shall cooperate with the ~~d~~Department and local agency in establishing paternity of a child eligible for Medicaid or applying for Medicaid, and identifying and collecting from any third party payer. Cooperation includes:

(i) Appearing at the Department or local agency office to provide information or evidence~~, under penalty of perjury,~~ regarding paternity;

(ii) Appearing as a witness at a court or other proceeding to testify regarding paternity;

(iii) Paying to the ~~d~~Department any medical support or medical ~~care funds~~ payments received that are covered by the assignment of benefits; ~~and~~

(iv) Upon request from the Department or local agency, taking any other reasonable steps to assist in establishing paternity, determining third party liability and securing payment from third party payers~~.~~; and

(v) Cooperating with the Department and the Department of Family Services in establishing paternity for applicable Medicaid births for the purposes of recovery of birth cost pursuant to W.S. §§ 42-4-122 and 14-2-1001 through 14-2-1008. Pursuant to W.S. §14-2-1003, not more than sixty (60) days after an unmarried client of Medicaid gives birth to a child, the

Department shall notify the Department of Family Services of the total birth cost. Total birth cost shall include:

(A) Maternity related expenditures including prenatal and postpartum care from nine (9) months prior to delivery through two (2) months after delivery, but not to exceed the average birth cost paid by Wyoming Medicaid.

(d) The refusal to cooperate in establishing paternity as set forth above, or the refusal to cooperate in locating third party payers or recovering payments from such payers, shall render such person ineligible for Medicaid, except as provided in 42 C.F.R. § 433.147 and 433.148~~(b)~~.

(e) Incentive allowance for Estate Recovery.

(i) The Department may allow an incentive payment to the heirs, legatees or other person(s), when the following conditions are met:

(A) An incentive allowance shall be the lesser of ten percent (10%) of the net proceeds from the sale of the asset(s), or two-thousand ($2,000.00) dollars:

(B) An incentive allowance shall be permitted only upon approval in writing by the Department or their designee, and only if the Medicaid benefits paid on behalf of the client exceeds the net proceeds; and

(C) The net proceeds from the sale shall be determined by deducting from the sale price the costs of discharging any encumbrances on the property and other reasonable expenses incurred preserving or disposing of the asset(s).

(f) If a Medicaid client is enrolled with a private health insurer, the client must follow the rules of the primary insurance, including using an in-network provider.

Section 7. Duties of Providers.

(a) Verify and obtain information. At the time a ~~recipient~~client requests services from a provider, the provider shall review the ~~recipient's~~client's eligibility card for information regarding third party payers. The provider shall ask the ~~recipient~~client if the information on the card is current and whether there are or may be additional third party payers. If the provider learns of a potential third party payer that is not listed on the eligibility card, the provider shall notify the Department in writing of that information within thirty (30) calendar days.

(b) Notify the Department of requests for information. ~~The provider shall notify the Department in writing of any requests for medical records or information regarding a recipient by the recipient, an attorney, or any other person or entity acting on behalf of the recipient~~client or a ~~third party.~~ Release of information by providers for casualty related third party resources not known to the State may be identified through requests for medical reports and bills received by providers from attorneys, insurance companies, and other parties. Providers shall contact the Department before responding to such requests.

(c) Notification of death.

(i) An institutional provider shall notify the Department, in writing, of ~~the~~any client's death ~~of any recipient~~which occurs in the facility or which occurs after the client is transported from the provider's facility to another facility, such as a hospital or hospice.

(ii) Time of notice. The notification shall be ~~mailed~~sent to the Department on or before the end of the third working day after the ~~recipient's~~client's death.

(iii) Contents of notice. The notification shall be in the form and contain the information required by the Department, as specified in the Provider Manual.

(d) Billing. Unless otherwise provided by a TPL waiver, this subsection shall govern the submission of bills involving third party payers.

(i) ~~Third party payer.~~ When a provider is informed ~~by a recipient, the Department or any other source~~ that the ~~recipien~~client has or may have coverage by a third party payer, the provider shall seek payment from the third party payer ~~before~~prior to submitting a Medicaid claim. When the amount payable by the third party payer ~~of third party liability~~ is less than the allowable Medicaid payment, the provider may submit a Medicaid claim for the difference ~~between the allowable Medicaid payment and the amount of third party liability~~. ~~Such~~ The Medicaid claim shall be accompanied by documentation of the amount payable by the third party payer ~~of third party liability~~or submitted electronically with the appropriate coordination of benefits information, including claims adjustment reason and remark codes.

(ii) ~~Rejection by third party payer.~~ If a third party payer rejects the request for payment, t~~T~~he provider may submit a Medicaid claim to the Department. ~~after receiving a written notice from the third party payer that a request for payment for services has been rejected. In such case,~~ ~~t~~The provider shall attach a copy of the notice of rejection to the Medicaid claim, upload a copy of the notice of rejection to the Medicaid web portal to be linked to the corresponding electronic claim, or submit the Medicaid claim electronically with the appropriate coordination of benefits information, including claims adjustment reason and remark codes. ~~The Department shall process the Medicaid claim subject to its normal procedures and standards.~~

(iii) ~~Failure to respond by third party payer.~~ ~~A~~If a provider ~~which~~ has not received payment or a rejection notice from a third party payer within ninety (90) days after submitting ~~a~~two (2) requests or attempts for payment, the provider may submit a Medicaid claim. The provider shall submit with the Medicaid claim, ~~a~~ copy~~y~~ies of the requests for payment to the third party payer, ~~documentation of an additional attempt to contact the third party payer,~~ and any written communication the provider has received from the third party payer. ~~The Department shall process the Medicaid claim subject to its normal procedures and standards.~~

(iv) ~~Submission of Medicaid claims after payment by third party payer.~~ A provider which has received payment from a third party payer may submit a Medicaid claim. In such cases the provider shall submit with the Medicaid claim documentation of the payment

received. The Department shall allow ~~such~~the Medicaid claim only to the extent the allowable Medicaid reimbursement exceeds the payment received from the third party payer and subject to the Department's normal procedures and standards.

(v) ~~Time limit for submission of Medicaid claims.~~ A provider shall submit Medicaid claims to the Department within twelve (12) months of the date of service or discharge, whichever is later, regardless of the potential involvement of a third party payer, except that Medicare crossover claims shall be submitted within six (6) months after the date of payment or rejection by Medicare. Medicaid claims submitted after the time limits specified in this paragraph shall be rejected. Refer to Chapter 3 of the Medicaid rules for further information.

(vi) For the purposes of paragraph (d)(i) of this section, any amount paid by Medicaid when combined with the amount paid by the third party payer, shall not exceed the amount payable to the provider under any preferred provider or similar agreement between the provider and that third party payer. The Department is only responsible for the patient's responsibility.

(vii) A provider shall not opt-out of participation with a third party payer. If a provider chooses to opt-out of participation with a third party payer, the Department shall not pay for services covered by, but not billed to, the third party payer. The provider shall work with the third party payer or client to have the claim submitted to the carrier.

(viii) If a provider chooses to bill Wyoming Medicaid, the provider accepts Medicaid payment as payment in full. The provider shall not bill Wyoming Medicaid and accept payment and bill the other third party. The provider shall choose whether to bill Wyoming Medicaid or bill the other party and wait for legal liability to be established.

Section 8. Payment or Rejection of Medicaid Claims Subject to Third Party Liability.

(a) Probable existence of liability of third party payer established at time of Medicaid claim. If the Department has established the probable existence of liability of a third party payer at the time a provider submits a Medicaid claim, the Department shall reject the Medicaid claim and return it to the provider for a determination of the amount of such liability.

(b) Establishing probable existence of liability of a third party payer. The probable existence of liability of a third party payer is established when the Department receives information from any source confirming the existence and extent of liability of a third party payer. ~~Then~~When the amount of liability is established, the Department shall process and pay Medicaid claims involving third party liability only to the extent that the Medicaid payment allowed by the Department's normal procedures and standards exceeds the amount of the third party payer's liability.

(c) Unavailability of third party payments. Third party payments are not available at the time of the submission of a Medicaid claim if the existence and extent of third party payer

liability is still disputed. If third party payments are not available, the Department shall process Medicaid claims subject to its normal procedures.

~~(d) Timely filing requirements. Providers are subject to the timely filing requirements of Chapter 3, which requirements are incorporated by this reference.~~.

(e~~d~~) Reconsideration. A provider may request that the Department reconsider a decision to ~~deny, reduce or~~ recover payments because of third party liability. Such request shall be made and shall be handled pursuant to the reconsideration provisions as set forth in Chapter 3, Section 14, of the Wyoming Medicaid Rules.

(e) Denial of improper claims. The Department shall deny claims which are improperly submitted or which contain errors of any kind. Denied claims may be resubmitted, subject to applicable federal and state requirements, including Chapter 1 and Chapter 16.

Section 9. Duties of Attorneys.

~~(a) Reporting requirements. If a recipient's right of recovery relates to an injury, illness, or disability for which the Department has made or is obligated to make Medicaid payments for services resulting from the injury, illness, or disability.~~

~~(i) The attorney for the plaintiff shall serve the Department with a copy of the complaint by certified mail, return receipt requested, within seven days after filing the complaint; and~~

~~(ii) The attorney for the plaintiff and the attorney for the defendant(s) shall:~~

~~(A) Notify the local agency and the Department, in writing, by certified mail, return receipt requested, of any settlement or judgment pursuant to which the recipient and/or third party receives or is to receive any benefits;~~

~~(B) Make the Wyoming Attorney General, representing the Director of the Department, a party to any negotiations involving settlement, compromise or release; and~~

~~(C) Comply with the requirements of this Chapter before disbursing any benefits.~~

(a) Attorneys shall be obligated to cooperate with the Department to recover under this Section in accordance with W.S. §§ 42-4-201 through 42-4-208.

(~~b~~b) ~~Before or at the time of disbursing funds to a recipient and/or attorney's fees, the~~An attorney ~~acting on behalf of the recipient~~ representing a Medicaid client shall not disburse any insurance proceeds to the Medicaid client or retain any portion as attorney's fees prior to submitting ~~to the Department:~~a statement of net recovery distribution and payment to the Department.

~~(iii) A Statement of Net Recovery Distribution substantially in the form specified in Attachment IV to the rules governing contingent fees; and~~

~~(iv) Payment of the Department's portion of the recovery.~~

~~(c) Failure to comply. An attorney who fails to comply with this Chapter is subject to the provisions of Section 10(i).~~

Section 10. Medicaid ~~t~~Third ~~p~~Party ~~l~~Liability ~~r~~Recovery.

~~(a) The Department may seek Medicaid benefit recovery pursuant to the procedures and standards of W.S. 42-4-201 *et seq*., which are incorporated by this reference, and applicable federal law.~~

~~(i) The Department shall have the right to bring an independent action or to intervene in any existing action in which a recipient's recovery is based, in whole or in part, on an illness, injury, or disability for which the Department has paid or is obligated to pay Medicaid funds for services furnished to the recipient.~~

(~~b~~a) The Department may not agree to a settlement which involves the compromise or release of any portion of the federal medical assistance percentage, except as allowed by federal law.

(~~c~~b) Amount of the Department's recovery. ~~Except as provided in paragraph (i), t~~The Department ~~shall~~may recover from any settlement or judgment involving a third party payer the full amount of Medicaid funds paid or to be paid on behalf of the ~~recipient~~client because of the injury, illness, or disability for which such payments were made.

(i) If~~, after notice pursuant to Section 9,~~ the Department ~~determines and states in writing that it will neither~~ does not file an independent action ~~n~~or intervene in an existing ~~one~~action, the Department shall calculate its reduced lien by deducting~~reduce its recovery by up to~~:

(A) Thirty-three ~~(33)~~ percent (33%) ~~as its proportionate share of~~for attorney's fees; and

(B) ~~The Department's~~A proportionate share of the reasonable attorney's costs incurred in ~~making~~obtaining the ~~recipient's~~client's recovery.

(I) The Department's proportionate share of the reasonable costs incurred in making the ~~recipient's~~client's recovery shall be determined by:

(1) Dividing the amount of the Department's recovery (the amount of Medicaid benefits reimbursed minus attorney's fees as provided in this Section) by the amount of the ~~recipient's~~client's gross recovery; and

(2) Multiplying the ~~resulting~~determined fraction by the reasonable costs incurred in making the recovery.

(II) For purposes of this section, "the reasonable attorney's costs incurred in making the ~~recipient's~~client's recovery" shall be court costs, costs of litigation, travel costs, expert witness fees, deposition expenses, and any other costs necessarily incurred in making the recovery. Reasonable costs shall be in the sole discretion of the Department and shall not include any items for which the client is not also responsible.

(ii) ~~If the Department determines that payment of the recipient's attorney and payment of Medicaid's claim will exhaust the gross settlement, and if the Department either is informed that the recipient will not pursue a claim or the Department is unable to learn despite reasonable effort whether the recipient will pursue a claim, t~~The Department may consider the cost-effectiveness of reducing its claim for reimbursement after evaluating all relevant ~~the following~~ factors, including:

(A) Available insurance coverage or other factors relating to the assets or solvency of the liable third party;

(B) Factual and legal issues pertaining to liability;

(C) ~~Problems of proof affecting the ability to obtain settlement or judgment~~Legal issues or restrictions on the Department's recovery, including problems of proof affecting the ability to obtain settlement or judgment and;

(D) Estimated fees and costs associated with the Department~~'s~~ pursuing ~~the~~ its claim.

(~~d~~) ~~The allocation of payments. The allocation of payments in a settlement agreement between medical expenses and/or any other category of payments shall have no effect on the State's right to recover the full amount of Medicaid funds paid on behalf of a recipient.~~

(~~e~~c) Structured settlements. ~~If the recipient enters into a structured settlement under which the initial payment to the recipient is insufficient to reimburse the Department for the amount determined pursuant to subsection 8(c), the recipient shall pay the Department all funds received in each installment until the Department is paid in full.~~A client's recovery shall not be placed in a structured settlement until the Department has been reimbursed and issued a release of its reimbursement right. If a client prematurely enters into a structured settlement under which the initial payment to the client is insufficient to reimburse the Department, the client shall pay the Department all funds received in each installment until the Department is paid in full. All structured settlements shall fully comply with the requirements pertaining to annuities under the Department's rules.

(~~f~~d) Future Medicaid payments. ~~after settlement. E~~Except as otherwise ~~provided in a settlement agreement approved pursuant to this Chapter~~agreed, the settlement of a client's claim

does not preclude the Department from seeking Medicaid benefit recovery for Medicaid payments made after the date of such settlement.

(ge) ~~The Department's right to recover from a third party payer, a provider, a recipient or a recipient's attorney.~~The Department shall have the right to recover directly from a third party payer to the extent of Medicaid funds paid or to be paid on behalf of a client when the existence and extent of liability of such third party payer is established. In situations where a Medicaid client was not represented by legal counsel, an attorney representing an insurance company shall not disburse any insurance proceeds to the Medicaid client prior to submitting a statement of available proceeds (declaration sheet), payment to the Department, and approval by the Department.

~~(i) Right to recover.~~

~~(A) The Department shall have the right to recover directly from a third party payer to the extent of Medicaid funds paid or to be paid to a provider on behalf of a recipient when the existence and extent of liability of such payer is established.~~

~~(B) A third party payer which pays a settlement or judgment remains liable for the Department's reimbursement right unless the Department, through the Wyoming Attorney General, signs a release before such payment.~~

(~~C~~f) ~~The Department shall have the right to recover directly from a recipient who has received money from a third party payer to the extent of Medicaid funds paid or to be paid on behalf of such recipient for which the third party payer is liable.~~The Department shall have the right to recover from any attorney who knowingly fails to notify the Department of any settlement of judgment or fails to ensure the Department is reimbursed to the extent of its reimbursement right.

(~~D~~g) The Department shall have the right to recover directly from a provider which has received Medicaid funds paid on behalf of a ~~recipient~~client to the extent the provider has received payments from a third party payer for the same services.

(~~E~~h) ~~The Department shall have the right to recover from a recipient's attorney who knowingly failed to report to the Department any settlement from which the state was entitled to reimbursement but did not receive it. The Department shall have the right to recover from any attorney who knowingly fails to notify the Department of any settlement of judgment or fails to ensure the Department is reimbursed.~~ The Department shall have the right to recover from any attorney who knowingly fails to notify the Department of any settlement or judgment or fails to ensure the Department is reimbursed to the extent of its reimbursement right.

(~~i~~) ~~Methods of recovery. The Department may attempt to recover Medicaid funds from a liable third party, including a third party payer, a provider, a recipient or a recipient's attorney by:~~

~~(i) Initiating a civil lawsuit against the liable third party, including a third party payer, provider, recipient or recipient's attorney;~~

~~(ii) Reducing any future Medicaid payments to be made to the provider to the extent the provider has received payments from a third party payer for services for which Medicaid has also paid; or~~

~~(iii) Any other method of collecting a debt or obligation permitted by law.~~

~~(i) Failure to comply.~~

~~(i) The failure of a recipient or recipient's attorney to comply with this chapter shall not affect the Department's right to recover from the recipient to the extent of third party liability.~~

~~(ii) The knowing failure of a recipient's attorney to notify the Department of any settlement and ensure reimbursement to the state shall result in the Department having a claim against the attorney to the extent of third party liability.~~

~~(iii) The Department shall report to the Board of Professional Responsibility of the Wyoming State Bar the failure of an attorney to notify the Department of any settlement or to ensure reimbursement to the State of its Reimbursement right.~~

Section 11. Estate ~~r~~Recoveries.

(a) Pursuant to W.S. § 42-4-207(c), t~~T~~he Department may ~~pursuant to W.S. § 42-4-207(c)~~ impose a pre-death lien against a ~~recipient's~~client's real property ~~if~~:

(i) If t~~T~~he ~~recipient~~client is an inpatient in a nursing facility, intermediate care facility for ~~the mentally retarded retarded~~people with intellectual disability, or other medical institution; and the client cannot reasonably be expected to be discharged from the facility and return home; or

(ii) ~~The Department of Family Services determines after notice and an opportunity for hearing that the recipient cannot reasonably be expected to be discharged from the medical institution and to return home;~~If the client has been institutionalized for ninety (90) days or longer without a discharge plan, it is presumed that the client will not be discharged and return home; however, the applicant or the client will be provided with a notice of their right to a hearing prior to a determination being made that the applicant or the client is permanently institutionalized.

~~(iii) Neither the recipient's spouse, child under age twenty-one (21), or child who is blind or disabled under 42 U.S.C. 1382c is lawfully residing in the home;~~

~~(iv) The recipient has no sibling lawfully residing in the home who has resided there at least one year before the recipient was admitted to the medical institution.~~

~~(b) Any lien imposed pursuant to W.S. 42-4-207(c) shall dissolve upon the individual's discharge from the medical institution and return home.~~

(~~c~~b) Pursuant to W.S. § 42-4-207(j), t~~T~~he Department, ~~may pursuant to W.S. § 42-4-207(j)~~ may impose a lien upon property of any estate, as defined in W.S. § 42-4-206(g), of a deceased client for the amount of medical assistance provided while the client was fifty-five (55) years of age or older or while the client was an inpatient in a nursing facility, intermediate care facility for people with intellectual disability or other medical institution. ~~the recipient's real and personal property upon the recipient's death.~~ The lien may be imposed regardless of the presence in the home of individuals ~~categorized~~ identified in ~~subsection (a)~~ W.S. § 42-4-207(e).

(i) For estate recovery purposes, the Department defines "legal title" for real property in W.S. § 42-4-206(g) to mean title of record in the county public property records.

(c) If the client has purchased a long-term care partnership certified policy, the Department shall take into consideration the benefits paid by the policy in determining the extent of estate recovery.

(d) The Department may recover against a lien imposed under W.S. § 42-4-207 only after the death of the ~~recipient's~~client's surviving spouse, if any, and ~~only at a time~~:

(i) ~~When~~If the ~~recipient~~client has no surviving child who is under age twenty-one (21), or is blind, ~~and~~or permanently and totally disabled~~;~~.

~~(ii) For liens imposed under W.S. 42-4-207(c) when:~~

~~(A) No sibling of the individual is lawfully residing in the recipient's home who was residing there for at least one year immediately before the recipient's admission to the medical institution;~~

~~(B) No child of the recipient is lawfully residing in the recipient's home who was residing there for at least two years immediately before the recipient's admission to the medical institution, and who establishes to the state's satisfaction that he or she provided care to the recipient that permitted the recipient to reside at home rather than the institution.~~

~~(e) The Department may pursuant to W.S. 42-4-206 file a claim in a probate action if:~~

~~(i) The recipient is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution;~~

~~(ii) The recipient has no surviving spouse, child under age twenty-one (21), or child who is blind or disabled under 42 U.S.C. 1382c;~~

(~~iii~~e) ~~If the~~A claim ~~is~~ filed pursuant to W.S. § 42-4-206(a) against the surviving spouse's estate, ~~the claim~~ is limited to the value of the assets of the estate determined to exist at the time of death of the surviving spouse that were marital property or jointly owned property at any time during the marriage.

~~(f) Procedures for recovery from probate estate.~~

~~(i) The Department shall be provided notice pursuant to W.S. 2-1-205(c) and 2-7-205(a)(iii) if Department made payment of Medicaid funds on behalf of the decedent.~~

~~(ii) The Department shall file its estate claim pursuant to W.S. 2-7-701 *et seq.* of the Wyoming Probate Code.~~

~~(g) The claim in a probate action shall be considered an expense of the last illness of the decedent.~~

(~~h~~f) The Department may foreclose its lien outside the probate action pursuant to W.S. §§ 2-~~1~~7-717.

(~~i~~g) Procedures for recovery from non-probate estate.

(i) The Department shall have the right to recover from non-probate assets pursuant to W.S. §§ 42-4-206 or 207, and shall have the discretion to ~~choose~~decide how to proceed.

(ii) The Department shall have the right to recover directly from a transferee or other individual or entity which has possession, control, or ownership of property received from the non-probate estate of a deceased ~~recipient~~client.

~~(iii) Methods of recovery. The Department may recover by:~~

~~(A) Initiating a civil action; or~~

~~(B) Any other method of collecting a debt or obligation permitted by law.~~

~~(j) The Department shall waive recovery under W.S. § 42-4-206 and 42-4-207 if recovery would work an undue hardship.~~

(~~k~~h) Any lien or claim against the estate or assets of a ~~recipient~~client age~~d~~ fifty-five (55) years or older when receiving medical assistance or an inpatient in a facility, intermediate care facility for people with intellectual disability or other medical institution shall be limited to amounts expended for nursing facility services, home and community-based services including waiver services, related hospital and prescription drug services, and any items or services under the State Plan.

(i) Reasonable expenses incurred in preserving or disposing of the assets are only allowed if:

(i) They are documented with specificity and by an itemized statement or ledger of expenses with copies of receipts,

(ii) They are paid by someone other than the client (use of the client's personal funds will not be reimbursable), and

(iii) They were paid after one of the following events occurred:

(A) Client entered a nursing facility, an assisted living facility, an intermediate care facility for people with intellectual disability, or other medical institution, never returned home, and failed to pay the expenses; or

(B) Client passed away.

(j) The Department may decline to pursue an estate recovery if it determines that it is not cost-effective to recover.

(k) Bona Fide Efforts to Sell. The Department may enter into a stipulation and consent agreement with Medicaid client(s), heirs, or legatees when the following conditions are met:

(i) The client has received Medicaid for a period of at least six (6) months;

(ii) Net proceeds shall be paid to the Department to reimburse medical payments made on behalf of the client;

(iii) The property shall be actively placed on the market;

(iv) The property shall not be sold for less than eighty percent (80%) of fair market value, unless the Department provides approval of the sale of the property for less than eighty percent (80%) of its value; and

(v) If the net proceeds exceed the amount of the Medicaid benefits paid, Medicaid will receive payment in full for the benefits and services provided to the Medicaid client(s) and eligibility for benefits shall be redetermined.

Section 12. Undue hHardship Waiver.

~~(a) If the Department determines that an estate recovery would be an undue hardship, the Department may waive part or all of the Department's share of the amount which is recoverable pursuant to this Chapter.~~

(~~b~~a) Notice of right to request undue hardship waiver. At the time the Department imposes a lien or files a probate claim, it shall provide written notice by mail to the personal representative or known heirs of the right to request an undue hardship waiver. ~~to the personal representative or known heirs who would take under the intestacy statute.~~

(~~c~~b) Request for undue hardship waiver.

(i) Any individual who receives notice pursuant to subsection (~~b~~a) may request an undue hardship waiver.

(ii) A request for an undue hardship waiver ~~must~~shall be mailed to the Department by certified mail, return receipt requested, within thirty-three (33) days of the date ~~the individual or entity receives~~ of the Department's notice pursuant to subsection (~~b~~a). The request ~~must~~shall include documentation that the decedent's home is part of the estate, that the decedent's home is part of a business, including a working farm or ranch, ~~and~~ show that recovery of the home would result in the heirs or beneficiaries losing their means of making a living, and provide other relevant documentation upon the Department's request. The failure to provide the information required by this paragraph with the request shall result in the dismissal with prejudice of the undue hardship waiver request.

(~~d~~c) Consideration of request. ~~Upon~~Within thirty (30) days of receipt of a request for an undue hardship waiver, the Department shall consider whether the information furnished shows an undue hardship. During the thirty (30) days of review, t~~T~~he Department may request additional information before making a final decision. The request shall be made in writing by certified mail, return receipt requested. The party to whom the request is directed shall provide the requested information within thirty (30) days after the receipt of the certified mail. The Department shall have fifteen (15) days from receipt of the additional information to make a decision. Failure to provide the requested information shall result in a denial of the request. The Department's decision shall be in writing, and shall be delivered by certified mail, return receipt requested. If the request is denied, the Department shall provide notice of the opportunity to request that the Department reconsider the decision.

(~~e~~d) Reconsideration. A party may request that the Department reconsider a decision to deny an undue hardship waiver. Such request shall be made and shall be handled pursuant to the reconsideration provisions as set forth in Chapter 3, Section 14, of the Wyoming Medicaid Rules. A party may submit any additional relevant information at the time of the request. A party that fails to request reconsideration pursuant to this section may not subsequently request an administrative hearing pursuant to Chapter 4 regarding the adverse action.

(~~f~~e) Administrative Hearing. If an administrative hearing is requested, it shall be conducted in accordance with Chapter 4, except the burdent of proof in subsection (f) applieds to this Chapter,

(~~g~~f) Burden of proof. ~~The party opposing Medicaid benefit recovery shall bear the burden of showing an undue hardship by a preponderance of the evidence.~~If an administrative hearing is requested, it shall be conducted in accordance with the Wyomign Medicaid Rules, Chapter 4, Medicaid Administrative Hearings, except the burden of proof in subsection (f) applies to this Chapter.

~~(f) The Department may elect not to pursue an estate recovery if it determines that it is not cost-effective to recover.~~

~~Section 13. Interpretation of Chapter.~~

~~(a) The order in which the provisions of this Chapter appear is not to be construed to mean that any one provision is more or less important than any other provision.~~

~~(b) The text of this Chapter shall control the titles of its various provisions.~~

~~**Section 14. Superseding Effect.** This Chapter supersedes all prior rules or policy statements issued by the Department, including Bulletins or Manuals, which are inconsistent with this Chapter.~~

~~**Section 15. Severability.** If any portion of this Chapter is found to be invalid or unenforceable, the remainder shall continue in full force and effect.~~

Section 13. Incorporation by Reference.

(a) For any code, standard, rule, or regulation incorporated by reference in this rules:

(i) The Department has determined that incorporation of the full text in these rules would be cumbersome or inefficient given the length or nature of the rules:

(ii) The incorporation by reference does not include any later amendments or editions of the incorporated matter beyond the applicable date identified in subsection (b) of this section; and

(iii) The incorporated code, standard, rule, or regulation is maintained at the Department and is available for public inspection and copying at cost at the same location.

(b) Each rule or regulation incorporated by reference in these rules is further identified as follows:

(i) Referenced in Section 2 and 5 is Title V of the Social Security Act, which is incorporated as the effective date of this Chapter and can be found at http://ssa.gov.

(ii) Referenced in Section 2 is Title XII of the Social Security Act, including 42 U.S.C. §§ 1396a(25), 1396k(a)(1)(A), and 1396p, which is incorporated as of the effective date of this Chapter and can be found at http://ssa.gov.

(iii) Referenced in Section 2 is 42 C.F.R. §§ 433.135 through 433.154, which is incorporated as of the effective date of this Chapter and can be found at http://www.ecfr.gov.

(iv) Referenced in Section 2 is 42 C.F.R. § 433.36, which is incorporated as of the effective date of this Chapter and can be found at http://www.ecfr.gov.

(v) Referenced in Section 2 is the Wyoming Medicaid State Plan, which is incorporated as of the effective date of this Chapter and can be found at https://health.wyo.gov/healthcarefin/medicaid/spa/.

(vi) Referenced in Section 5 is 42 U.S.C. § 1396d(b), which is incorporated as of the effective date of this Chapter and can be found at http://ssa.gov.

(vii) Referenced in Section 6 is 42 C.F.R. § 433.148(b), which is incorporated as of the effective date of this Chapter and can be found at http://www.ecfr.gov.

(viii) Institutional Provider Manual at: wymedicaid.portal.conduent.com/manuals, go to provider, select provider manuals and bulletins, choose institutional manual, and go to Medicaid Death Report Form.