Certification Page
Regular and Emergency Rules
Revised June 2020

☐ Emergency Rules *(Complete Sections 1-3 and 5-6)* ☒ Regular Rules

1. General Information			
a. Agency/Board Name* Wyoming Department of Health			
b. Agency/Board Address 401 Hathaway Building, 2300 Capitol Ave.	c. City Cheyenne	d. Zip Code 82002	
e. Name of Agency Liaison Heather Canarecci	f. Agency Liaison Telephone Number 307-777-8028		
g. Agency Liaison Email Address heather.canarecci2@wyo.gov	h. Adoption Date April 21, 2021		
i. Program Medicaid			
Amended Program Name (*if applicable*):			

* ☐ *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 (non-emergency) 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 non-emergency or regular rules new as per the above description and the definition of "new" in Chapter 1 of the Rules on Rules?

☒ No. ☐ Yes. If the rules are new, please provide the Legislative Chapter Numbers and Years Enacted (e.g. 2015 Session Laws Chapter 154):

3. Rule Type and Information For purposes of this Section 3, "New" means an emergency or regular rule that has never been previously created.

a. Provide the Chapter Number, Title* and Proposed Action for Each Chapter. *Please use the "Additional Rule Information" form to identify additional rule chapters.*

Chapter Number:	Chapter Name:	Action
18	Medicaid Eligibility	☐ New ☒ Amended ☐ Repealed
	Amended Chapter Name (*if applicable*):	
Chapter Number:	Chapter Name:	☐ New ☐ Amended ☐ Repealed
	Amended Chapter Name (*if applicable*):	
Chapter Number:	Chapter Name:	☐ New ☐ Amended ☐ Repealed
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	Amended Chapter Name (*if applicable*):	
Chapter Number:	Chapter Name:	☐ New ☐ Amended ☐ Repealed
	Amended Chapter Name (*if applicable*):	

4. Public Notice of Intended Rulemaking

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

b. A public hearing was held on the proposed rules. ■ No. ☐ Yes. **Please complete the boxes below.**

Date:	Time:	City:	Location:

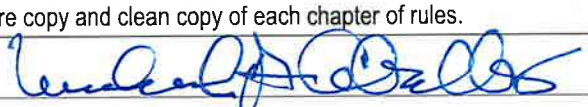
5. Checklist

a. ☑ For regular rules, the Statement of Principal Reasons is attached to this Certification 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

b. ☐ For emergency rules, the Memorandum to the Governor documenting the emergency, which requires promulgation of these rules without providing notice or an opportunity for a public hearing, is attached to this Certification.

6. Agency/Board Certification

The undersigned certifies that the foregoing information is correct. By electronically submitting the emergency or regular rules into the Wyoming Administrative Rules System, the undersigned acknowledges that the Registrar of Rules will review the rules as to form and, if approved, the electronic filing system will electronically notify the Governor's Office, Attorney General's Office, and Legislative Service Office of the approval and electronically provide them with a copy of the complete rule packet on the date approved by the Registrar of Rules. The complete rules packet includes this signed certification page; the Statement of Principal Reasons or, if emergency rules, the Memorandum to the Governor documenting the emergency; and a strike and underscore copy and clean copy of each chapter of rules.

Signature of Authorized Individual	
Printed Name of Signatory	Michael A. Ceballos
Signatory Title	Director
Date of Signature	April 21, 2021

7. Governor's Certification

I have reviewed these rules and determined that they:

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

Therefore, I approve the same.

Governor's Signature	
Date of Signature	

WYOMING MEDICAID RULES

CHAPTER 18

MEDICAID ELIGIBLITY

Intent to Amend Rules

Statement of Reasons

The Wyoming Department of Health (WDH) proposes to proposes to adopt the following amended rule pursuant to its statutory authority under Wyoming Statutes §§ 42-4-101 through 42-4-122.

Chapter 18 of the Wyoming Medicaid Rules is being amended to update the language and grammar throughout the Chapter. Various redundancies were removed and sections were reorganized to clarify the overall process of Medicaid Eligibility. In addition, the following Sections were updated:

- Section 5 (a)(ii), General Eligibility Requirements, has been updated to specify that the criteria for a Wyoming resident excludes those who intend to return to a home property in another state.

- Section 5(b), General Eligibility Requirements, has been added to specify suspension for Medicaid eligible clients who are incarcerated.

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

Medicaid

Amendment to Chapter 18

Chapter 18
Medicaid Eligibility

The Wyoming Department of Health did not receive any public comments.

CHAPTER 18

MEDICAID ELIGIBLITY

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

Section 2. Purpose and Applicability.

(a) This Chapter has been adopted to describe an individual's rights and responsibilities associated with Medicaid eligibility, to establish uniform procedures and to define eligibility groups.

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

Section 3. Definitions.

(a) Except as otherwise specified in Chapter 1 of the Wyoming Medicaid Rules or as defined in this Section, the terminology used in this Chapter is the standard terminology and has the standard meaning used in health care, Medicaid, and Medicare.

(b) "Relative" means a parent, child, stepchild, grandparent, grandchild, brother, sister, stepbrother, stepsister, aunt, uncle, niece, nephew, whether by birth or adoption, and whether by whole or half-blood, of the individual or individual's current or former spouse.

(c) "Fiduciary" means an individual's attorney-in-fact, guardian, conservator, legal custodian, caretaker, trustee, attorney, accountant, or agent."

Section 4. Application Process, Applicant Rights and Responsibilities.

(a) Application Process.

(i) Applicants shall submit an application in the manner and form prescribed by the Department. The application shall be completed, dated, and signed by the applicant or by any person who is assisting the applicant.

(ii) Applications shall be processed within the following time frames:

(A) Aged, Blind and Disabled programs:

(I) Forty-five (45) days from the date of application, or

(II) Sixty (60) days from the date of application when waiting on documentation from a third party to use in determining eligibility, or

(III) Ninety (90) days from the date of application when waiting for a disability determination to be completed by the Wyoming Department of Health or designee.

(B) Family and Children's programs:

(I) Forty-five (45) days from the date of application, or

(II) Sixty (60) days from the date of application when waiting on documentation from a third party to use in determining eligibility.

(iii) Applicants shall be notified in writing of the reasons for the approval, denial or closure, the specific regulation supporting the action, and an explanation of the right to request a hearing, as specified in 42 C.F.R. § 431.210 and W.S. § 42-4-108.

(iv) Any individual who has been determined eligible by the Social Security Administration for Supplemental Security Income (SSI) is not required to complete an application.

(v) Applicants shall be allowed to receive retroactive Medicaid benefits not to exceed three (3) calendar months prior to the application if the individual received Medicaid covered services at any time during that period, and would have been eligible for Medicaid had they applied, unless restricted by other federal and state laws and regulations.

(b) Applicant Rights.

(i) Applicants shall be allowed the opportunity to apply for Medicaid without delay.

(ii) Applicants may be accompanied, assisted, or represented by an individual or individuals of their choice during the application process.

(iii) Applicants may request assistance completing the applications or obtaining required verification.

(iv) Applicants shall be informed of the following information in writing and verbally as appropriate:

(A) The eligibility requirements;

(B) Available Medicaid services; and

(C) The rights and responsibilities of individuals.

(v) If an administrative hearing is requested, it shall be conducted in accordance with Wyoming Medicaid Rules, Chapter 4, Medicaid Administrative Hearings.

(c) Applicant Responsibilities.

(i) Applicants shall cooperate in the eligibility process by providing all information and documentation requested by the Department, including, but not limited to, income, resources, and trusts.

(ii) Applicants who fail to cooperate or provide the information requested by the Department shall be denied eligibility.

(d) Eligibility Period and Redeterminations.

(i) Medicaid eligibility begins the first day of the month in which the individual is eligible, except for eligibility under the Presumptive Programs, eligibility begins the day the application is submitted and approved.

(ii) Individuals under age 19 and women on the Family Planning Waiver are deemed to be continuously eligible for Medicaid for twelve (12) months from the effective date of eligibility or for twelve (12) months from the last review.

(iii) The Department shall redetermine an individual's eligibility every twelve (12) months.

Section 5. General Eligibility Requirements

(a) In addition to meeting the requirements of this Chapter, applicants shall meet the following requirements to be eligible for Medicaid:

(i) Applicants shall be citizens or nationals of the United States, and shall provide a social security number and provide proof of identity. Pregnant women considered to be lawfully present satisfy the citizenship and alienage eligibility requirements.

(ii) Applicants shall be a Wyoming resident or meet the criteria, as specified in the Medicaid State Plan. An individual who intends to return to home property in another state, shall not be considered a Wyoming resident.

(b) Individuals eligible for Wyoming Medicaid who are incarcerated will be reviewed for continued coverage at the time of notification of incarceration. If the incarcerated individual remains eligible for Wyoming Medicaid, benefits will be suspended. Renewals and applications received for incarcerated individuals will be processed and if approved, benefits will be authorized but suspended until release from the public institution. Inpatient claims will be considered for payment for incarcerated clients while suspended.

Section 6. Family and Children's Eligibility.

(a) The following individuals are eligible for Medicaid:

(i) Children born to a Medicaid eligible woman are deemed to have applied for medical assistance and to have been found eligible on the date of birth and to remain eligible for a period of thirteen (13) months.

(ii) Children birth through age five (5), whose countable family income does not exceed one hundred fifty-four percent (154%) of the Federal Poverty Level (FPL).

(iii) Children age six (6) through age eighteen (18), whose countable family income does not exceed one hundred thirty-three percent (133%) of the FPL.

(iv) Foster care children are eligible for Medicaid under Title IV-E of the Social Security Act.

(v) Foster care children who are not eligible under Title IV-E of the Social Security Act and are in the custody of the Department of Family Services (DFS).

(vi) Adopted children who live in Wyoming and are under a Wyoming Subsidized Adoption Agreement remain eligible for Medicaid until age twenty-one (21).

(vii) Children who were in DFS custody at the time of their eighteenth (18th) birthday and are released from custody at that time or later are eligible for Medicaid until age twenty-six (26).

(viii) A woman who is pregnant and whose family income does not exceed one hundred fifty-four percent (154%) of the FPL is eligible for Medicaid during the pregnancy and through a sixty (60) day period beginning on the last day of the pregnancy.

(ix) A woman who is pregnant and whose family income does not exceed the income eligibility levels specified in the Medicaid State Plan under Title XIX of the Social Security Act shall be eligible for Medicaid during the pregnancy and through a sixty (60) day period beginning on the last day of the pregnancy. Qualified Pregnant Women shall cooperate in establishing paternity, and obtaining medical support during the sixty (60) day postpartum period.

(x) A woman who is age nineteen (19) but under the age of forty-five (45) whose family income does not exceed one hundred fifty-nine percent (159%) and is transitioning from the Pregnant Women Program shall be eligible for Medicaid coverage for certain family planning services.

(xi) Caretaker relatives of a dependent child, as specified in 42 C.F.R. 435.110, whose family income does not exceed the income eligibility levels specified in the Medicaid State Plan shall be eligible for Medicaid. Adults must cooperate in establishing paternity and obtaining medical support.

(xii) Caretaker relatives of a dependent child under the age of eighteen (18) whose family income exceeds the Family Care income eligibility levels due to the receipt of spousal support, and who have received Family Care benefits for three (3) of the last six (6) months shall be eligible for an extension of Medicaid benefits for four (4) months.

(xiii) Caretaker relatives of a dependent child under the age of eighteen (18) whose family income exceeds the Family Care income eligibility levels due to an increase in earning of the caretaker, and who have received Family Care benefits for three (3) of the last six (6) months shall be eligible for an extension of Medicaid benefits for four (12) months.

(xiv) Medicaid benefits shall be available to individuals who are infected with tuberculosis.

(b) For all eligibility categories described in Section 6(a) of this Chapter which include an income requirement, income shall be calculated using the modified adjusted gross income of the household.

(c) A resource test does not apply to any of the groups described in Section 6(a).

(d) Individuals shall immediately report changes in any of the following circumstances to the Department:

(i) Income;

(ii) Household composition;

(iii) Health insurance; and

(iv) Address.

Section 7. Presumptive Eligibility.

(a) Eligibility shall begin on the date on which a qualified provider or qualified hospital determines that an individual is eligible for presumptive eligibility and ends with the earlier of:

(i) The day on which Medicaid eligibility is determined; or

(ii) The last of day of the month following the month in which the determination of presumptive eligibility was made.

(b) Presumptive Eligibility determinations may be conducted by:

(i) Qualified provider, or

(ii) Qualified Hospital.

(c) Presumptive Eligibility shall be limited to:

(i) Pregnant women whose family income does not exceed one hundred fifty-four percent (154%) of FPL shall be eligible for temporary outpatient services. A pregnant woman shall be eligible for one (1) presumptive eligibility period per pregnancy.

(ii) Children under age six (6) whose family income does not exceed one-hundred fifty-four percent (154%) of FPL and children age six (6) through eighteen (18) whose family income does not exceed one-hundred thirty-three percent (133%) of FPL shall be eligible for all services covered under the State Plan. A child shall be eligible for one (1) presumptive eligibility period every twelve (12) months.

(iii) Parents and other Caretaker relatives of a dependent child, whose family income does not exceed the income eligibility levels specified in the Medicaid State Plan shall be eligible for all services covered under the State Plan for this group. The individual shall be eligible for (1) presumptive eligibility period every twelve (12) months.

(iv) Certain individuals needing treatment for Breast or Cervical Cancer whose income does not exceed two hundred fifty percent (250%) of FPL shall be eligible for all services covered under the State Plan for this group. The individual shall be eligible for (1) presumptive eligibility period every twelve (12) months.

(v) Former foster care children who were in DFS custody at the time of their eighteenth (18th) birthday and were receiving Medicaid benefits under the State Plan at that time or later, shall be eligible for all services covered under the State Plan for this group up to age twenty-six (26). The individual shall be eligible for (1) presumptive eligibility period every twelve (12) months.

(d) Status as a qualified provider or qualified hospital may be terminated if staff at a qualified provider or qualified hospital knowingly provides false information to influence a presumptive eligibility determination. Providers may request reconsideration by contacting the Department and then request an Administrative Hearing in accordance with Chapter 4 of the Wyoming Medicaid Rules.

Section 8. Aged, Blind or Disabled Eligibility.

(a) Eligibility Requirements for the Aged, Blind or Disabled.

(i) Age sixty-five (65) or over;

(ii) Legally blind as certified by an optical professional or the Social Security Administration (SSA); or

(iii) An individual who is determined disabled by the SSA or the Department.

(b) The following individuals are eligible for Medicaid:

(i) Individuals entitled to Supplemental Security Income (SSI).

(ii) Any aged, blind, or disabled individual who loses eligibility for SSI benefits due to an increase in income, but who would be eligible for SSI if the Cost of Living Adjustments (COLA) received since the SSI termination were disregarded.

(iii) Individuals who lose SSI benefits due to the entitlement of SSA widow/widower benefits, as defined in Section 1634(b) of the Social Security Act.

(iv) Individuals who are Aged, Blind or Disabled and reside in a Medical institution, receive hospice services in accordance with a voluntary election, or receive Home and Community Based Services under a waiver and have income at or below three hundred percent (300%) of the payment standard. Individuals shall reside in a medical institution for thirty (30) consecutive days or more, unless the individual is eligible for SSI or dies before completion of the thirty (30) consecutive.

(c) Treatment of Income.

(i) Income of a spouse is not available to the other spouse when applying for Inpatient Hospital Care, Employed Individuals with Disabilities, Nursing Home, Hospice, or Home and Community Based Services under a waiver, pursuant to Section 1915(c) of the Social Security Act.

(ii) A parent's income is available to a child until the month after the child attains age eighteen (18) if the child lives in the parent's home. A parent's income is not available to a child if the child is married, institutionalized for more than thirty (30) days, or if the child applies for assistance under a Home and Community Based Services waiver or the Employed Individuals with Disabilities program.

(iii) To qualify for an Income Trust exception the trust shall be treated in accordance with Section 1917(d)(4)(B), 42 U.S.C. 1396p and be:

(A) Irrevocable.

(B) Composed only of pension, Social Security, and other income to the individual and accumulated income in the trust.

(C) Provide that the Department will receive all amounts remaining in the trust upon the death of the individual up to the amount equal to the total amount of medical assistance paid on behalf of the beneficiary.

(D) Allow a monthly distribution of three hundred percent (300%) of the SSI payment standard for programs with no patient contribution, reasonable costs of administering the trust, and a Community Spouse allowance.

(E) Allow a monthly distribution to pay towards the cost of nursing facility services, less allowable deductions. Deductions shall be allocated, as specified in 42 C.F.R. § 435.725, except the trust may provide that the trustee pay any reasonable costs of administering the trust; and

(F) Not allow any portion of the principal to be available to the individual.

(G) Penalties for transferred resources shall not apply to resources transferred into an Income Trust.

(d) Treatment of Resources.

(i) Resources shall be determined to be available to the individual when the individual has the legal right, authority, or power to liquidate.

(ii) Resources shall be determined to be unavailable to the individual when there is a legal barrier that prevents the access or right to dispose of the resource. The individual shall pursue reasonable steps to overcome the legal barrier unless it is determined by the Department that the cost of pursuing legal action would exceed the resource value of the property or that it is unlikely the individual would succeed in the legal action.

(iii) A home, as defined by Chapter 1 of the Wyoming Medicaid Rules, is an excluded resource.

(iv) Medicaid may disregard any resources claimed by an individual in an amount equal to or less than the benefits paid on behalf of the individual by a Qualified Long-Term Care Partnership Policy as defined by W.S. § 42-7-102(a)(v).

(v) Resources shall not exceed the SSI resource limits, as specified in 20 C.F.R. § 416.1205. Individuals who are Aged, Blind or Disabled and reside in a medical institution, receive Hospice Services, or receive Home and Community Based Services under a waiver shall receive an additional Community Spouse allowance as specified in Section 1924 of the of the Social Security Act.

(vi) Treatment of Trusts.

(A) Revocable and Irrevocable Trusts shall be treated in accordance with W. S. §§ 42-2-402 and 42-2-403 and Sec. 1917(d)(3) [42 U.S.C. 1396p].

(B) Resources within a Special Needs Trust that is established in accordance with W. S. § 42-2-402, 42-2-403 and Section 1917(d)(4)(A) [42 U.S.C. 1396p] shall be considered an excluded resource.

(I) The Trustee shall obtain the consent of the Department prior to early termination of a Special Needs Trust pursuant to W.S. § 4-10-412. The Department shall consent to termination of a Special Needs Trust prior to the individual's death when a court order is entered providing that the Department shall be fully reimbursed from the Special Needs Trust. The Department shall be joined as a party to any such proceedings and served with a copy of all pleadings.

(II) All Special Needs Trusts shall have a valid Spendthrift provision that complies with the laws of every state in which the individual has received Medicaid benefits.

(III) The Department is a Qualified Beneficiary defined in W.S. § 4-10-103(a)(xv)(E).

(IV) Distributions.

(1.) Distributions ~~s~~hall be for the sole benefit of the disabled individual and shall be used to provide for the individual's special needs; and

(2.) Distributions for funeral expenses shall not be paid after the beneficiary's death until the Department and all other state Medicaid agencies are fully reimbursed.

(3.) Distribution shall only be allowed for the individual's basic needs when the Trustee has proven to the Department that the disabled individual's basic needs are not adequately being provided for by government assistance programs.

(V) All contributions from third parties to a Special Needs Trust shall be deemed an irrevocable gift to the disabled individual, and the third party shall not be able to redirect resources transferred to the trust, or otherwise exert any interest or control over the resources in the trust.

(VI) When the Special Needs Trust has or will receive annuity payments, structured settlement payments, or any other periodic payments, the payments shall be titled in the name of the trust.

(VII) The trustee shall provide an annual accounting of the trust income and expenditures to the Department. The Department may request more frequent accountings at its discretion.

(VIII) All distributions to or for the benefit of the beneficiary, unless paid directly to a third party, shall be income to the beneficiary.

(IX) No portion of the principal shall be available to the beneficiary.

(X) When the beneficiary dies or the trust is terminated, the trustee shall notify the Department and provide a sworn affidavit with an accounting within two (2) months after the individual's death.

(C) Pooled Trusts shall be established in accordance with W.S. § 42-2-403(f)(iii) and Section 1917(d)(4)(C) [42 U.S.C. 1396p].

(I) The Pooled Trust shall be established for the sole benefit of an individual who is under age sixty-five (65) and disabled according to the criteria set forth in 42 U.S.C. § 1382c(a)(3), by the individual, parent, grandparent, legal guardian of the disabled individual, or by a court.

(II) The Pooled Trust shall provide that upon the death of the beneficiary or termination of the trust during the beneficiary's lifetime, which every is sooner, the Department receives any amount, up to the amount of medical assistance benefits paid on behalf of the beneficiary, remaining in the beneficiary's trust account after deduction for reasonable administrative fees and expenses, and an additional remainder amount.

(III) All distributions from the Pooled Trust shall be for the sole benefit of the beneficiary and shall be used to provide for the beneficiary's special needs.

(1.) Any distribution from the trust paid directly to the beneficiary shall be considered income available to the beneficiary.

(2.) Distributions for funeral expenses shall not be paid after the beneficiary's death until the Department and all other Medicaid agencies in other states are fully reimbursed.

(IV) Penalties for transferred resources shall not apply to resources transferred into a Pooled Trust, except that all amounts transferred to the Pooled Trust by the beneficiary or beneficiary's spouse after the beneficiary turns age sixty-five (65) shall be subject to a transfer penalty as specified in subsection (h) below.

(vii) Real property shall be considered unavailable to the individual for purposes of resource determinations when:

(A) Bona Fide Effort To Sell Agreement when the client has been eligible for Medicaid for six months or more, or

(B) Conditional Benefits Agreement when the individual has been eligible for Medicaid for less than six months.

(e) Personal Care Contracts

(i) A "Personal Care Contract" (PCC) is an agreement between a caregiver and an aged, blind or disabled individual to provide caregiver services for fair market value. Payments made to family members through a PCC to delay or prevent entrance into a long term care facility are considered transfers for fair market value only if the agreement meets the requirements in this Section and documentation is provided to the Department upon request.

(ii) The PCC shall be a detailed writing that includes:

(A) The date the care begins,

(B) A detailed description of the services to be provided,

(C) How often services will be provided,

(D) How much the caregiver will be compensated;

(E) When the caregiver will be compensated,

(F) How long the agreement is to be in effect,

(G) A statement that the terms of the agreement can be modified only by mutual agreement of the parties and approved by the Department,

(H) The location where services will be provided, and

(I) The notarized signature of both parties.

(iii) The following services may be provided through a PCC when the individual is receiving unduplicated services at home and are not in a facility: preparing meals, shopping, medication management, transportation to medical appointments, paying bills, light housekeeping, and assistance with activities of daily living.

(iv) No services shall be provided under a PCC while an individual resides in a long term care facility or receives services under a Waiver program. A caregiver shall not duplicate services provided by a home health aide, nurse, medical professional, or other care provider hired to assist the individual regardless of whether the individual resides in a long term care facility or receives services within their home.

(v) "Advocating for services" shall not be an allowable service under a PCC.

(vi) The Department shall verify the fair market value of these services through the use of the U.S. Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook see https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm?view_full.

(vii) Caregivers shall not receive payment in advance of services performed. Prepayments made to caregivers shall be considered a transfer for less than fair market value.

(viii) A PCC shall not be retroactive and shall be considered a transfer for less than fair market value in accordance with subsection (h) of this Chapter.

(f) Patient Contribution.

(i) Deductions from the individual's gross income shall be allowed in determining the amount of the individual's monthly contribution to be paid toward the cost of care in a medical facility.

(ii) Allowable deductions shall be applied in accordance with the Social Security Act, 42 § C.F.R. 435.725 and the Medicaid State Plan.

(iii) An individual temporarily in an institution shall be allowed a maintenance deduction not to exceed one hundred fifty dollars ($150.00) per month for up to six (6) months to maintain the home, except:

(A) The deduction shall not be allowed when a physician verifies the individual will not be able to return to the home within six (6) months; or

(B) The deduction is not allowed if the ~~client~~ individual has a spouse who is not institutionalized.

(iv) Deductions for a community spouse who lives in the community when the married partner lives in a medical institution, receives services under a Home & Community Based Services Waiver, or Hospice Care, shall be applied in the manner prescribed in Title XIX of the Social Security Act, 42 C.F.R. 435.725 and the Medicaid State Plan.

(g) Benefits begin:

(i) After completion of thirty (30) consecutive days in a medical institution or thirty (30) days after a hospice election.

(ii) The first day of the month during which the plan of the care is approved by the Department for the Home and Community Based Services Waiver Program, and after all eligibility requirements are met.

(h) Transfer penalties:

(i) A transfer penalty shall be imposed for nursing facility or home and community based services when an individual or the individual's spouse disposes of income or resources for less than fair market value on or after the look-back period, as prescribed in Section 1917(c) of the Social Security Act 42 U.S.C. § 1396p(c), and W.S. § 42-2-402.

(A) It is presumed that a transfer for less than fair market value was made for the purpose of qualifying for Medicaid in the following circumstances.

(I) An inquiry about Medicaid benefits was made, by or on behalf of the individual, to any person before the date of the transfer, or;

(II) A transfer was made by the individual or on the individual's behalf to a relative of the individual, a relative of the individual's spouse, or to the individual's fiduciary.

(B) The fair market value of real property shall be based on an appraisal or market analysis of the property at the time of the sale or transfer of the property. The individual has the obligation to provide the Department with an appraisal or market analysis. Failure to provide the requested documentation shall result in a denial of eligibility.

(C) For a resource to be considered transferred for fair Market value or to be considered to be transferred for valuable consideration, the compensation received for the resource shall be in a tangible form with intrinsic value A transfer for love and consideration is not considered a transfer at fair market value. Services provided for free at the time performed were intended to be provided without compensation.

(I) A transfer to a relative for care provided without compensation in the past is a transfer for less than fair market value.

(II) An individual can rebut this presumption with tangible evidence that is acceptable to the Department. Such evidence shall be in writing at the time services were provided to be considered by the Department.

(D) A transfer penalty shall be reduced in the amount of returned resources to the individual or paid directly to a provider on behalf of the individual. The amount of returned resources shall be determined using Fair Market Value.

(I) A return of resources to pay for attorney fees during a contested case shall not reduce the penalty period for the individual. Attorney fees are the sole responsibility of the individual.

(II) A request for an undue hardship shall be made in writing and include documentation to support and demonstrate an undue hardship in accordance with Section 8.

(E) Undue hardship will be considered if the transfer penalty would deprive the individual of food, clothing, shelter, or other necessities of life or medical care such that the individual's health or life would be endangered, verified with the Medicaid Hardship Exception Request and Physician Statement and one of the following has occurred:

(I) It is determined that the person who received the transferred resource cannot be located by the individual, the individual's spouse, the individual's fiduciary, or an agent of the nursing facility, after all attempts to locate the person have been exhausted; or

(II) The resource transferred was due to theft, fraud, or financial exploitation of the individual or their spouse, which has been reported and pursued through Adult Protective Services or law enforcement; or

(III) The individual or their fiduciary has exhausted all reasonable legal means to recover or regain possession or obtain fair market value of the transferred resource or income. "Exhausting all reasonable legal means to recover" may include seeking the advice of an attorney and pursuing legal or equitable remedies, such as asset freezing, assignment, or injunction; seeking modification, avoidance, or nullification of a financial instrument, promissory note, mortgage, or other transfer agreement; cooperating with any attempt to recover the transferred asset; making a referral to Adult Protective Services; filing a police report; and seeking recovery through the court.

(i) Individuals shall be responsible for reporting to the Department any changes in the following:

(i) Income;

(ii) Resources;

(iii) Household size;

(iv) Health insurance; and

(v) Address.

Section 9. Breast and Cervical Cancer Treatment Program.

(a) The Department's Public Health Division's Breast and Cervical Cancer Early Detection Program identifies applicants in need of treatment for either breast or cervical cancer. Financial eligibility is determined by the Department's Division of Healthcare Financing or designee.

(b) Eligibility Requirements.

(i) Countable family income is less than or equal to two hundred and fifty percent (250%) of the Federal Poverty Level.

(ii) Income shall be calculated using the modified adjusted gross income of the household, as specified in 42 C.F.R. § 435.603 and the State Plan.

(iii) Individuals shall be under the age of 65.

(iv) Individuals shall not be eligible for Medicaid or have health insurance.

(v) Eligibility shall be reviewed by the Department for continued eligibility every twelve (12) months.

(c) Individuals shall be responsible for reporting to the Department any changes in the following:

(i) Income;

(ii) Health insurance;

(iii) Address; and

(iv) Conclusion of treatment

Section 10. Employed Individuals with Disabilities Eligibility Group.

(a) Medicaid benefits are available to individuals with disabilities who work and pay a monthly premium for their healthcare coverage.

(b) Eligibility Requirements.

(i) Countable unearned income shall be less than or equal to three hundred percent (300%) of the Supplemental Security Income (SSI) payment standard.

(ii) Resource tests do not apply for this eligibility group.

(iii) Individuals shall be age sixteen (16) through sixty-four (64).

(iv) An individual shall be employed part-time or full-time during a specified payroll period. The individual can be considered employed when not working, but on temporary absence due to medical leave.

(v) The individual shall pay a monthly premium, as calculated according to W.S. §§ 42-4-115 and 42-4-116.

(vi) If an individual otherwise meets the criteria for the Comprehensive, Support or Acquired Brain Injury Waiver, but does not meet the income or resource requirements, the individual may retain waiver services through the Employed Individuals with Disabilities program.

(c) Individuals shall be responsible for reporting to the Department any changes in the following:

(i) Income;

(ii) Household size;

(iii) Health insurance;

(iv) Address; and

(v) Employment.

Section 11. Medicare Savings Programs.

(a) Qualified Medicare Beneficiary (QMB). Medicaid shall assist individuals eligible for QMB with paying their Medicare premiums, cost sharing and deductibles, as specified in Sections 1902(a)(10)(E)(i) and 1905(p)(1) of the Social Security Act. Individuals shall meet the following eligibility requirements:

(i) Entitled to Medicare.

(ii) Countable income shall be equal to or less than one hundred percent (100%) of the Federal Poverty Level (FPL).

(iii) Countable resources shall not exceed three (3) times the SSI resource limit, as adjusted annually by the increase in the consumer price index.

(b) Specified Low-Income Medicare Beneficiary (SLMB). Medicaid shall assist individuals eligible for SLMB with paying their Medicare Part B premium, as specified in Section 1902(a)(10)(E)(iii) of the Social Security Act. Individuals shall meet the following eligibility requirements:

(i) Entitled to Medicare.

(ii) Countable income shall be more than one hundred percent (100%) of the FPL but less than or equal to one hundred twenty percent (120%) of the FPL.

(iii) Countable resources shall not exceed three (3) times the SSI resource limit, as adjusted annually by the increase in the consumer price index.

(c) Qualified Individual (QI). Medicaid can assist eligible individuals with paying their Medicare premiums, as specified in Section 1902(a)(10)(E)(iv) of the Social Security Act. Individuals shall meet the following eligibility requirements:

(i) Entitled to Medicare.

(ii) Countable income shall be more than one hundred twenty percent (120%) of the FPL but less than or equal to one hundred thirty-five percent (135%) of the FPL.

(iii) Countable resources shall not exceed three (3) times the SSI resource limit, as adjusted annually by the increase in the consumer price index.

(d) Eligibility shall be re-determined by the Department every twelve (12) months for all groups within this section.

(e) Individuals shall be responsible for reporting to the Department any changes in the following:

(i) Income;

(ii) Resources;

(iii) Household size;

(iv) Health insurance; and

(v) Address.

Section 12. Emergency Services. Applicants who are not citizens or nationals of the United States, but otherwise meet the eligibility requirements of the State Plan, are eligible for limited emergency services, as specified in 42 C.F.R. § 440.255. Applicants who do not meet the citizenship or alienage requirements shall not be eligible for emergency services under the Nursing Home, Home and Community Based Services under a waiver pursuant to Section 1915(c) of the Social Security Act, Hospice, Presumptive Eligibility, Family Planning Waiver, EID, Breast and Cervical Cancer, and Tuberculosis programs.

Section 13. Delegation of Duties. The Department may delegate any of its duties under this rule to the Wyoming Attorney General, Health and Human Services, any other agency of the federal, state or local government, or a private entity which is capable of performing such functions, provided that the Department shall retain the authority to impose sanctions, recover overpayments or take any other final action authorized by this Chapter.

CHAPTER 18

MEDICAID ELIGIBLITY

Section 1. Authority.

This Chapter is promulgated pursuant to ~~Title XIX of the Social Security Act, 20 C.F.R., Chapter III, Part. 416; 42 C.F.R., Chapter IV, Subchapter C, Part 435; 45 C.F.R., Subtitle B, Chapter II, Part 233;~~ the Medical Assistance and Services Act at Wyoming Statute~~s~~ (W.S.) ~~§ 42-4-101 through 42-4-306; Wyoming Statute~~ § 42-4-104 (a)(iv) ~~and Wyoming Statute § 9-2-106~~.

Section 2. Purpose and Applicability.

(a) This Chapter has been adopted to describe ~~a Medicaid applicant and client's~~ an individual's rights and responsibilities associated with Medicaid eligibility, to establish uniform procedures ~~for Medicaid eligibility,~~ and to define eligibility groups.

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

Section 3. Definitions.

(a) Except as otherwise specified in Chapter 1 of the Wyoming Medicaid Rules or as defined in this Section, the terminology used in this Chapter is the standard terminology and has the standard meaning used in health care, Medicaid, and Medicare.

(b) "Relative" means a parent, child, stepchild, grandparent, grandchild, brother, sister, stepbrother, stepsister, aunt, uncle, niece, nephew, whether by birth or adoption, and whether by whole or half-blood, of the individual or individual's current or former spouse.

(c) "Fiduciary" means an individual's attorney-in-fact, guardian, conservator, legal custodian, caretaker, trustee, attorney, accountant, or agent."

Section 4. Application Process, Applicant Rights and Responsibilities.

(a) Application Process.

(i) Applicants shall submit an application in the manner and form prescribed by the Department~~, except when the individual is eligible for Supplemental Security Income (SSI)~~. The application shall be completed, dated, and signed by the applicant or by any person who is assisting the applicant.

~~(A) Any individual who knowingly makes a false statement or misrepresentation or knowingly fails to disclose a material fact in obtaining benefits may be guilty of a misdemeanor or felony, as specified in Wyoming Statute § 42-4-111~~.

(ii) Applications shall be ~~acted on~~ processed within the following time frames:

.

(A) Aged, Blind and Disabled programs:

(I) Forty-five (45) days from the date of application, or

(II) Sixty (60) days from the date of application when waiting on ~~verification~~ documentation from a third party to use in determining eligibility, or

(III) Ninety (90) days from the date of application when waiting for a disability determination to be completed by the Wyoming Department of Health or designee.

(B) Family and Children's programs:

(I) Forty-five (45) days from the date of application~~.~~, or

(II) Sixty (60) days from the date of application when waiting on documentation from a third party to use in determining eligibility.

(iii) Applicants shall be notified in writing of the reasons for the ~~action~~ approval, denial or closure, the specific regulation supporting the action, and an explanation of the right to request a hearing, as specified in 42 C.F.R. §~~§ 431.206 and~~ 431.210 and W.S. § 42-4-108.

(iv) ~~A record of all action taken shall be documented in the case file, as specified in 42 C.F.R. § 435.914~~. Any individual who has been determined eligible by the Social Security Administration for Supplemental Security Income (SSI) is not required to complete an application.

(v) Applicants shall be allowed to receive retroactive Medicaid benefits not to exceed three (3) calendar months prior to the application if the individual received Medicaid covered services at any time during that period, and would have been eligible for Medicaid had they applied, ~~as specified in 42 C.F.R. § 435.915,~~ unless restricted by other federal and state laws and regulations.

(b) Applicant Rights.

(i) Applicants shall be allowed the opportunity to apply for Medicaid without delay~~, as required by 42 CF.R. § 435.906~~.

(ii) Applicants may be accompanied, assisted, or represented by an individual or individuals of their choice during the application process~~, as required by 42 C.F.R. § 435.908~~.

(iii) Applicants may request assistance completing the applications or obtaining required verification.

(iv) Applicants shall be informed of the following information in writing and verbally as appropriate:

(A) The eligibility requirements;

(B) Available Medicaid services; and

(C) The rights and responsibilities of ~~applicants and clients~~ individuals.

(v) ~~Confidentiality. Applications and other personal identifying information are confidential and shall not be disclosed, except as follows:~~ If an administrative hearing is requested, it shall be conducted in accordance with Wyoming Medicaid Rules, Chapter 4, Medicaid Administrative Hearings.

~~(A) To ensure any medical assistance does not duplicate any benefit payment made by another state agency, insurer, group health plan, third party administrator, health maintenance organization or similar entity, upon request of the state agency, insurer or similar entity, the Department may disclose the client's name, social security number, amount of payment, charges for services, dates of services, and services rendered, as provided by Wyoming Statute § 42-4-112.~~

~~(B) To ensure any medical assistance does not duplicate any benefit payment made by another state agency, insurer or similar entity, the Department may request the limited information listed in (A) above from such entities.~~

~~(vi) Administrative Hearing. If an administrative hearing is requested, it shall be conducted in accordance with Wyoming Medicaid Rules, Chapter 4, Medicaid Administrative Hearings.~~

~~(vii) Civil Rights. Applicants shall not be excluded, denied benefits, or otherwise discriminated against on the grounds of race, color, sex, religion, political belief, national origin, age, or disability.~~

(c) Applicant Responsibilities.

(i) Applicants shall cooperate in the eligibility process ~~of determining eligibility~~ by providing all information and documentation requested by the Department, including, but not limited to, income, resources, and trusts.

(ii) ~~Applicants shall assign, to the Department any right to medical support and to payment for medical care from a third party to the extent that Medicaid has paid for medical services.~~ Applicants who fail to cooperate or provide the information requested by the Department shall be denied eligibility.

~~(iii) Applicants who fail to cooperate or provide the information requested by the Department shall be denied eligibility.~~

(d) Eligibility Period and Redeterminations.

(i) ~~Effective Dates of Benefits.~~ Medicaid eligibility begins the first day of the month in which the individual is eligible, except for eligibility under the Presumptive Programs, eligibility begins the day the application is submitted and approved.

~~(A) Begin dates. Medicaid eligibility begins the first day of the month in which the individual is eligible, as specified in 42 C.F.R. § 435.915 and the Medicaid State Plan under Title XIX of the Social Security Act, except that eligibility under the Presumptive Programs, eligibility begins the day the application is submitted and approved, as specified in Section 1920 of the Social Security Act.~~

~~(B) Eligibility Period. Individuals under age 19 and women on the the Family Planning Waiver are deemed to be continuously eligible for Medicaid for 12 months from the effective date of eligibility or for 12 months from the last periodic review.~~

(ii) ~~Redetermination of Eligibility. The Agency shall redetermine an individual's eligibility every 12 months.~~ Individuals under age 19 and women on the Family Planning Waiver are deemed to be continuously eligible for Medicaid for twelve (12) months from the effective date of eligibility or for twelve (12) months from the last review.

(iii) The Department shall redetermine an individual's eligibility every twelve (12) months.

Section 5. General Eligibility Requirements. ~~In addition to meeting the requirements under Section 6 (Family and Children's Eligibility), Section 8 (Aged, Blind or Disabled Eligibility), Section 9 (Special Eligibility Groups), or Section 10 (Employed Individuals with Disabilities Eligibility Group), Section 11 (Medicare Savings Programs) of this Chapter, applicants shall meet the following requirements to be eligible for Medicaid:~~

(a) ~~Citizenship and Alienage. Applicants shall be citizens or nationals of the United States, as specified in 42 C.F.R. § 435.406. Applicants who are not citizens or nationals of the United States, but otherwise meet the eligibility requirements of the State Plan, are eligible for limited emergency services, as specified in 42 C.F.R. § 440.255, except as set forth in Section 12 of this Chapter.~~ In addition to meeting the requirements of this Chapter, applicants shall meet the following requirements to be eligible for Medicaid:

(i) ~~Pregnant women considered to be lawfully present satisfy the citizenship and alienage eligibility requirements.~~ Applicants shall be citizens or nationals of the United States, and shall provide a social security number and provide proof of identity. Pregnant women considered to be lawfully present satisfy the citizenship and alienage eligibility requirements.

(ii) Applicants shall be a Wyoming resident or meet the criteria, as specified in the Medicaid State Plan. An individual who intends to return to home property in another state, shall not be considered a Wyoming resident.

(b) ~~Identification. Applicants shall provide proof f identity, as specified in 42 C.F.R. § 435.407.~~ Individuals eligible for Wyoming Medicaid who are incarcerated will be reviewed for continued coverage at the time of notification of incarceration. If the incarcerated individual remains eligible for Wyoming Medicaid, benefits will be suspended. Renewals and applications received for incarcerated individuals will be processed and if approved, benefits will be authorized but suspended until release from the public institution. Inpatient claims will be considered for payment for incarcerated clients while suspended.

~~(c) Residency. Applicants shall reside in Wyoming or meet the criteria, as specified in 42 C.F.R. § 435.403.~~

~~(d) Social Security Number. Applicants who are citizens or nationals of the United States shall provide a social security number.~~

Section 6. Family and Children's Eligibility.

(a) The following individuals are eligible for Medicaid:

(i) Children born to a Medicaid eligible woman are deemed to have applied for medical assistance and to have been found eligible on the date of birth and to remain eligible for a period of thirteen (13) months~~, as specified in 42 C.F.R. § 435.117~~.

(ii) Children birth through age five (5), whose countable family income does not exceed one hundred fifty-four percent (154%) of the Federal Poverty Level (FPL)~~, are eligible for Medicaid as specified in 42 C.F.R. § 435.118~~.

(iii) Children age six (6) through age eighteen (18), whose countable family income does not exceed one hundred thirty-three percent (133%) of the FPL ~~are eligible for Medicaid as specified in 42 C.F.R. § 435.118~~.

(iv) Foster care children are eligible for Medicaid under Title IV-E of the Social Security Act.

(v) Foster care children who are not eligible under Title IV-E of the Social

Security Act and are in the custody of the Department of Family Services (DFS) ~~are eligible for Medicaid, as specified in 42 C.F.R. § 435.222~~.

(vi) Adopted children who live in Wyoming and are under a Wyoming Subsidized Adoption Agreement remain eligible for Medicaid until age twenty-one (21)~~, as specified in 42 C.F.R. § 435.145, 42 C.F.R. § 435.222 and Section 1902 (a)(10)(A)(ii)(VIII) of the Social Security Act~~.

(vii) Children who were in DFS custody at the time of their eighteenth (18th) birthday and are released from custody at that time or later,~~ as specified in Sections 1902(a)(10)(A)(ii)(XVII) and 1905(w)(1) of the Social Security Act,~~ are eligible for Medicaid until age twenty-six (26)~~ one (21).~~

(viii) ~~Children who were in DFS custody at the time of their eighteenth (18th) birthday and were receiving Medicaid benefits under the State Plan at that time or later, as specified in 42 C.F.R. § 435.150, shall be eligible for Medicaid until age twenty-six (26).~~ A woman who is pregnant and whose family income does not exceed one hundred fifty-four percent (154%) of the FPL is eligible for Medicaid during the pregnancy and through a sixty (60) day period beginning on the last day of the pregnancy.

(ix) ~~Poverty-Level Pregnant Women. A woman who is pregnant and whose family income does not exceed one hundred fifty-four percent (154%) of the FPL is eligible for Medicaid during the pregnancy and through a sixty (60) day period beginning on the last day of the pregnancy, as specified in 42 C.F.R. § 435.116.~~ A woman who is pregnant and whose family income does not exceed the income eligibility levels specified in the Medicaid State Plan under Title XIX of the Social Security Act shall be eligible for Medicaid during the pregnancy and through a sixty (60) day period beginning on the last day of the pregnancy. Qualified Pregnant Women shall cooperate in establishing paternity, and obtaining medical support during the sixty (60) day postpartum period.

(x) ~~Qualified Pregnant Women. A woman who is pregnant and whose family income does not exceed the income eligibility levels specified in the Medicaid State Plan under Title XIX of the Social Security Act shall be eligible for Medicaid during the pregnancy and through a sixty (60) day period beginning on the last day of the pregnancy, as specified in 42 C.F.R. § 435.116, and Sections 1902(a)(10)(A)(i)(III) and 1905(n)(l) of the Social Security Act. Qualified Pregnant Women shall cooperate in establishing paternity, and obtaining medical support during the sixty (60) day postpartum period, as specified in 42 C.F.R. § 433.147.~~ A woman who is age nineteen (19) but under the age of forty-five (45), whose family income does not exceed one hundred fifty-nine percent (159%) of FPL and is transitioning from the Pregnant Women Program shall be eligible for Medicaid coverage for certain family planning services.

(xi) ~~Family Planning Waiver. A woman who is age nineteen (19) but under the age of forty-five (45), whose family income does not exceed one hundred fifty-nine percent (159%) of FPL and is transitioning from the Pregnant Women Program shall be eligible for Medicaid coverage for certain family planning services, as specified in 42 C.F.R. § 435.214 and Section 1115(a) of the Social Security Act.~~ Caretaker relatives of a dependent child, as specified in 42 C.F.R. 435.110, whose family income does not exceed the income eligibility

levels specified in the Medicaid State Plan shall be eligible for Medicaid. Adults must cooperate in establishing paternity and obtaining medical support

(xii) ~~Family Care. Caretaker relatives of a dependent child, as specified in 42 C.F.R. 435.110, whose family income does not exceed the income eligibility levels specified in the Medicaid State Plan shall be eligible for Medicaid. Adults must cooperate in establishing paternity and obtaining medical support. as specified in 42 C.F.R. § 433.147 and Section 1931 of the Social Security Act.~~ Caretaker relatives of a dependent child under the age of eighteen (18) ~~nineteen (19)~~ whose family income exceeds the Family Care income eligibility levels due to the receipt of spousal support, and who have received Family Care benefits for three (3) of the last six (6) months shall be eligible for an extension of Medicaid benefits for four (4) month

(xiii) ~~Four (4) Month Extended Medicaid. Caretaker relatives of a dependent child under the age of eighteen (18) nineteen (19) whose family income exceeds the Family Care income eligibility levels due to the receipt of spousal support, and who have received Family Care benefits for three (3) of the last six (6) months shall be eligible for an extension of Medicaid benefits for four (4) months, as specified in 42 C.F.R. § 435.115.~~ Caretaker relatives of a dependent child under the age of eighteen (18) whose family income exceeds the Family Care income eligibility levels due to an increase in earning of the caretaker, and who have received Family Care benefits for three (3) of the last six (6) months shall be eligible for an extension of Medicaid benefits for four (12) months.

(xiv) ~~Twelve (12) Month Extended Medicaid. Caretaker relatives of a dependent child under the age of eighteen (18) nineteen (19) whose family income exceeds the Family Care income eligibility levels due to an increase in earning of the caretaker, and who have received Family Care benefits for three (3) of the last six (6) months shall be eligible for Medicaid for an extension of Medicaid benefits for four (12) months extended period of time, as specified in 42 C.F.R. § 435.112.~~ Medicaid benefits shall be available to individuals who are infected with tuberculosis.

~~(xv) Tuberculosis Assistance Program. Medicaid benefits shall be available to individuals who are infected with tuberculosis, as specified in 42 C.F.R. § 435.215.~~

(b) ~~Treatment of Income.~~ For all eligibility categories described in Section 6(a) of this Chapter which include an income requirement, income shall be calculated using the modified adjusted gross income of the household.

~~(i) For all eligibility categories described in Section 6(a) of this Chapter which include an income requirement, income shall be calculated using the modified adjusted gross income of the household as specified in 42 C.F.R. § 435.603 and the State Plan.~~

(c) ~~Treatment of Resources.~~ A resource test does not apply to any of the groups described in Section 6(a).

(d) ~~Reporting Changes.~~ ~~Clients~~ Individuals shall immediately report changes in any of the following circumstances to the Department:

(i) Income;

(ii) Household composition;
(iii) Health insurance; and

(iv) Address.

Section 7. Presumptive Eligibility.

(a) ~~Effective Dates of Benefits.~~ Eligibility shall begin on the date on which a qualified provider ~~entity~~ or qualified hospital determines that an individual is eligible for presumptive eligibility and ends with the earlier of:

(i) The day on which ~~a~~ Medicaid eligibility is determined ~~application is given a determination~~; or

(ii) The last of day of the month following the month in which the determination of presumptive eligibility was made.

(b) Presumptive Eligibility determinations may be conducted by:

(i) Qualified providers~~, as specified in Social Security Act § 1920~~; or

(ii) Qualified Hospitals~~, as specified in 42 C.F.R. § 435.1110~~.

(c) Presumptive Eligibility shall be limited to:

(i) Pregnant women whose family income does not exceed one hundred fifty-four percent (154%) of FPL shall be eligible for temporary outpatient services~~, as specified in Sections 1902(a)(47) and 1920 of the Social Security Act~~. A pregnant woman shall be eligible for one (1) presumptive eligibility period per pregnancy.

(ii) Children under age six (6) whose family income does not exceed one-hundred fifty-four percent (154%) of FPL and children age six (6) through eighteen (18) whose family income does not exceed one-hundred thirty-three percent (133%) of FPL shall be eligible for all services covered under the State Plan~~, as specified in 42 C.F.R. § 435.1102~~. A child shall be eligible for one (1) presumptive eligibility period every twelve (12) months.

(iii) ~~Eligibility groups specified in 42 C.F.R. § 435.1102 and 42 C.F.R. § 435.1103 that are elected in the State Plan .~~Parents and other Caretaker relatives of a dependent child, whose family income does not exceed the income eligibility levels specified in the Medicaid State Plan shall be eligible for all services covered under the State Plan for this group. The individual shall be eligible for (1) presumptive eligibility period every twelve (12) months.

(iv) Certain individuals needing treatment for Breast or Cervical Cancer whose

income does not exceed two hundred fifty percent (250%) of FPL shall be eligible for all services covered under the State Plan for this group. The individual shall be eligible for (1) presumptive eligibility period every twelve (12) months.

(v) Former foster care children who were in DFS custody at the time of their eighteenth (18th) birthday and were receiving Medicaid benefits under the State Plan at that time or later, shall be eligible for all services covered under the State Plan for this group up to age twenty-six (26). The individual shall be eligible for (1) presumptive eligibility period every twelve (12) months.

(d) Status as a qualified provider or qualified hospital may be terminated if staff at a qualified provider or qualified hospital knowingly provides false information to influence a presumptive eligibility determination. Providers may request reconsideration ~~seek corrective action~~ by contacting the Department ~~or~~ and then request~~ing~~ an Administrative Hearing ~~pursuant to~~ in accordance with Chapter 4 of the Wyoming Medicaid Rules.

~~(e) Presumptive Eligibility determinations must be made in accordance with Department policy, 42 C.F.R. § 435.1101, 42 C.F.R. § 435.1102, and 42 C.F.R. § 435.1110.~~

Section 8. Aged, Blind or Disabled Eligibility.

(a) Eligibility Requirements for the Aged, Blind or Disabled.

(i) ~~Aged, Blind or Disabled. The applicant/client shall be~~ Age sixty-five (65) or over;

~~(A) Age sixty-five (65) or over;~~

~~(B) Legally blind as certified by an optical professional or the Social Security Administration (SSA); or~~

~~(C) An individual who is determined disabled by the SSA or the Department., as specified in Section 1614(a)(3) of the Social Security Act; 42 C.F.R. Chapter IV, Subchapter C, Part 435, Subpart F; and 20 C.F.R. Chapter III, Part 416, Subpart I.~~

(ii) Legally blind as certified by an optical professional or the Social Security Administration (SSA); or

(iii) An individual who is determined disabled by the SSA or the Department.

(b) The following individuals are eligible for Medicaid:

(i) Individuals entitled to Supplemental Security Income (SSI)~~, as specified in Section 1902(a)(10)(A)(i)(II) of the Social Security Act~~.

(ii) Any aged, blind, or disabled individual who loses eligibility for

~~Supplemental Security Income (~~SSI~~)~~ benefits due to an increase in income, but who would be eligible for SSI if the Cost of Living Adjustments (COLA) received since the SSI termination were disregarded~~, as specified in 42 C.F.R. § 435.135~~.

(iii) ~~A child who was receiving SSI on the date of the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and lost SSI due to the new definition of disability, as determined by the SSA.~~ Individuals who lose SSI benefits due to the entitlement of SSA widow/widower benefits, as defined in Section 1634(b) of the Social Security Act.

(iv) ~~Individuals who lose SSI benefits due to the entitlement of SSA widow/widower benefits, as specified in Section 1634(b) of the Social Security Act.~~ Individuals who are Aged, Blind or Disabled and reside in a Medical institution, receive hospice services in accordance with a voluntary election, or receive Home and Community Based Services under a waiver and have income at or below three hundred percent (300%) of the payment standard. Individuals shall reside in a medical institution for thirty (30) consecutive days or more, unless the individual is eligible for SSI or dies before completion of the thirty (30) consecutive.

~~(v) Individuals who are Aged, Blind or Disabled and reside in a medical institution, receive hospice services in accordance with a voluntary election, or receive Home and Community Based Services (HCBS) under a waiver pursuant to Section 1915(c) of the Social Security Act and have income at or below three hundred percent (300%) of the Supplemental Security Income (SSI) payment standard, as specified in 42 C.F.R. § 435.1005. Individuals shall reside in a medical institution for thirty (30) consecutive days or more, unless the individual is eligible for SSI or dies before completion of the thirty (30) consecutive days, as specified in Section 1902(a)(10)(A)(ii)(V) of the Social Security Act.~~

(c) Treatment of Income.

(i) Income of a spouse is not available to the other spouse ~~for individuals described in Section 8(a) above~~ when applying for Inpatient Hospital Care, Employed Individuals with Disabilities, Nursing Home, Hospice, or Home and Community Based Services under a waiver, pursuant to Section 1915(c) of the Social Security Act.

(ii) A parent's income is available to a child until the month after the child attains age eighteen (18) if the child lives in the parent's home. A parent's income is not available to a child if the child is married, institutionalized for more than thirty (30) days, or if the child applies for assistance under a Home and Community Based Services waiver pursuant to Section 1915(c) of the Social Security Act or the Employed Individuals with Disabilities program.

~~(iii) Income of a spouse is not deemed available to the other spouse when applying for Inpatient Hospital Care, Employed Individuals with Disabilities, Nursing Home, Hospice, or Home and Community Based Services under a waiver, pursuant to Section 1915(c)~~

~~of the Social Security Act.~~ To qualify for an Income Trust exception the trust shall be treated in accordance with Section 1917(d)(4)(B), 42 U.S.C. 1396p and be:

(A) Irrevocable.

(B) Composed only of pension, Social Security, and other income to the individual and accumulated income in the trust.

(C) Provide that the Department will receive all amounts remaining in the trust upon the death of the individual up to the amount equal to the total amount of medical assistance paid on behalf of the beneficiary.

(D) Allowed a monthly distribution of three hundred percent (300%) of the SSI payment standard, for programs with no patient contribution, reasonable costs of administering the trust, and a Community Spouse allowance.

(E) Allow a monthly distribution to pay towards the cost of nursing facility services, less allowable deductions. Deductions shall be allocated, as specified in 42 C.F.R. § 435.725, except the trust may provide that the trustee pay any reasonable costs of administering the trust, and

(F) Not allow any portion of the principal to be available to the individual.

(G) Penalties for transferred resources shall not apply to resources transferred into an Income Trust.

~~(iv) To qualify for an Income Trust exception, as specified in Section 1917 of the Social Security Act and Wyoming Statute § 42-2-403:~~

~~(A) The trust shall be irrevocable.~~

~~(B) The trust shall be composed only of pension, Social Security, and other income to the individual and accumulated income in the trust;~~

~~(C) The trust shall provide that the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.~~

~~(D) The trust shall allow a monthly distribution of three hundred percent (300%) of the Supplemental Security Income Federal Payment, as prescribed in 42 C.F.R. § 435.1005, for programs with no patient contribution, reasonable costs of administering the trust, and a Community Spouse allowance according to Section 1924 of the Social Security Act.~~

~~(E) The trust shall allow a monthly distribution to pay towards the cost of nursing facility services, less allowable deductions. Deductions shall be allocated, as specified~~

~~in 42 C.F.R. § 435.725, except the trust may provide that the trustee pay any reasonable costs of administering the trust.~~

~~(F) No portion of the principal shall be considered available to the individual.~~

~~(G) Transfer Penalties. Penalties for transferred resources shall not apply to resources transferred into an Income Trust.~~

(d) Treatment of Resources.

(i) Resources shall be determined to be available to the ~~applicant or client~~ individual when the ~~applicant or client~~ individual has the legal right, authority, or power to ~~make the resource available~~ liquidate~~, as specified in 20 C.F.R. Chapter. III, Part 416, Subpart L~~.

(ii) Resources shall be determined to be unavailable to the ~~applicant or client~~ individual when there is a legal ~~impediment~~ barrier that ~~precludes~~ prevents the access or right to dispose~~al~~ of the resource. The ~~applicant or client~~ individual shall pursue reasonable steps to overcome the legal ~~impediment~~ barrier unless it is determined by the Department that the cost of pursuing legal action would exceed the resource value of the property or that it is unlikely the ~~applicant or client~~ individual would succeed in the legal action.

(iii) ~~Real property shall be determined to be unavailable if the property cannot be sold because the property is jointly owned and its sale would cause undue hardship through the loss of housing for the other owner or owners, or because reasonable efforts to sell the property have been unsuccessful~~ A home, as defined by Chapter 1 of the Wyoming Medicaid Rules, is an excluded resource.

(iv) Medicaid may disregard any resources claimed by an individual ~~applicant or client~~ in an amount equal to or less than the benefits paid on behalf of the individual by a Qualified Long-Term Care Partnership Policy as defined by W.S. § 42-7-102(a)(v).

~~(A) "Qualified Long-Term Care Partnership Policy" means a policy that meets all of the requirements as specified in Wyoming Statute § 42-7-102(a)(v).~~

(v) Resources shall not exceed the SSI resource limits, as specified in 20 C.F.R. § 416.1205.~~except that~~ ~~i~~Individuals who are Aged, Blind or Disabled and reside in a medical institution, receive Hospice Services, or receive Home and Community Based Services under a waiver shall receive an additional Community Spouse allowance as specified in Section 1924 of the of the Social Security Act.

(vi) Treatment of Trusts.

(A) ~~Revocable Trusts. The principal of a revocable trust shall shall be an available resource when the applicant or client can revoke the trust and reclaim the trust resources.~~ Revocable and Irrevocable Trusts shall be treated in accordance with W. S. § 42-2-402 and 42-2-403 and Sec. 1917(d)(3) [42 U.S.C. 1396p].

(B) ~~Irrevocable Trusts.~~ Resources within a Special Needs Trust that is established in accordance with W. S. §§ 42-2-402, 42-2-403 and Section 1917(d)(4)(A) [42 U.S.C. 1396p] shall be considered an excluded resource.

(I) ~~The principal of an irrevocable trust shall be an available resource when:~~ The Trustee shall obtain the consent of the Department prior to early termination of a Special Needs Trust pursuant to W.S. § 4-10-412. The Department shall consent to termination of a Special Needs Trust prior to the individual's death when a court order is entered providing that the Department shall be fully reimbursed from the Special Needs Trust. The Department shall be joined as a party to any such proceedings and served with a copy of all pleadings.

~~(1.) The resources of the individual or spouse were used to form all or part of the principal of the trust; and~~

~~(2.) Payments from the trust could be made available to or for the benefit of the individual or spouse. The portion of the principal from which payments could be made available to or for the benefit of the individual or spouse shall be an available resource. If the terms of a trust provide for the support of the applicant or client, the refusal of a trustee to make a distribution from the trust does not render the trust an unavailable resource.~~

(II) ~~The principal of an irrevocable trust shall be determined to be unavailable when the resources of someone other than the individual or spouse (i.e., a third party) were used to form the principal of the irrevocable trust unless the terms of the trust permit the individual to require the trustee to distribute principal or income to the individual or spouse.~~ All Special Needs Trusts shall have a valid Spendthrift provision that complies with the laws of every state in which the individual has received Medicaid benefits.

(III) ~~Payments made from the portion of the principal of an irrevocable trust to or for the benefit of the individual shall be income of the individual.~~ The Department is a Qualified Beneficiary defined in W.S. § 4-10-103(a)(xv)(E).

(IV) Distributions.

(1.) Distributions ~~s~~hall be for the sole benefit of the disabled individual and shall be used to provide for the individual's special needs; and

(2.) Distributions for funeral expenses shall not be paid after the beneficiary's death until the Department and all other state Medicaid agencies are fully reimbursed.

(3.) Distribution shall only be allowed for the individual's basic needs when the Trustee has proven to the Department that the disabled individual's basic needs are not adequately being provided for by government assistance programs.

(V) All contributions from third parties to a Special Needs Trust shall be deemed an irrevocable gift to the disabled individual, and the third party shall not be able to redirect resources transferred to the trust, or otherwise exert any interest or control over the resources in the trust.

(VI) When the Special Needs Trust has or will receive annuity payments, structured settlement payments, or any other periodic payments, the payments shall be titled in the name of the trust.

(VII) The trustee shall provide an annual accounting of the trust income and expenditures to the Department. The Department may request more frequent accountings at its discretion.

(VIII) All distributions to or for the benefit of the beneficiary, unless paid directly to a third party, shall be income to the beneficiary.

(IX) No portion of the principal shall be available to the beneficiary.

(X) When the beneficiary dies or the trust is terminated, the trustee shall notify the Department and provide a sworn affidavit with an accounting within two (2) months after the individual's death.

(C) ~~Special Needs Trusts shall be established in accordance with Wyoming Statute § 42-2-403(f)(i) and Section 1917 of the Social Security Act.~~ Pooled Trusts shall be established in accordance with W.S. § 42-2-403(f)(iii) and Section 1917(d)(4)(C) [42 U.S.C. 1396p].

(I) ~~The Trustee shall obtain the consent of the Department prior to early termination of a Special Needs Trust pursuant to Wyoming Statute § 4-10-412. The Department shall consent to termination of a Special Needs Trust prior to the individual's death when a court order is entered providing that the Department shall be fully reimbursed from the Special Needs Trust.~~ The Pooled Trust shall be established for the sole benefit of an individual who is under age sixty-five (65) and disabled according to the criteria set forth in 42 U.S.C. § 1382c(a)(3), by the individual, parent, grandparent, legal guardian of the disabled individual, or by a court.

(II) ~~All Special Needs Trusts shall have a valid spendthrift provision that complies with the laws of every state in which the individual has received Medicaid benefits.~~ The Pooled Trust shall provide that upon the death of the beneficiary or termination of the trust during the beneficiary's lifetime, which every is sooner, the Department receives any amount, up to the amount of medical assistance benefits paid on behalf of the

beneficiary, remaining in the beneficiary's trust account after deduction for reasonable administrative fees and expenses, and an additional remainder amount.

(III) ~~To qualify for a Special Needs Trust exception and exclude the resources within the trust, the Special Needs Trust shall:~~ All distributions from the Pooled Trust shall be for the sole benefit of the beneficiary and shall be used to provide for the beneficiary's special needs.

(1.) ~~Be irrevocable;~~ Any distribution from the trust paid directly to the beneficiary shall be considered income available to the beneficiary.

(2.) ~~Be established for the sole benefit of an individual who is under age sixty-five (65) and disabled according to the criteria set forth in 42 U.S.C. § 1382c(a)(3);~~ Distributions for funeral expenses shall not be paid after the beneficiary's death until the Department and all other Medicaid agencies in other states are fully reimbursed.

~~(3.) Contain only the assets of a disabled individual who is under age sixty-five (65) when the trust is established. Any assets placed in the trust after age sixty-five (65) are not subject to the exception;~~

~~(4.) Be established by a parent, grandparent, legal guardian or a court consistent with Wyoming Statutes §§ 42-2-403(f), 4-10-401(a)(iv) and 3-3-607(a)(vi); and~~

~~(5.) Provide that the state shall receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total amount of medical assistance paid on behalf of the individual.~~

(IV) ~~The Trustee shall obtain the consent of the Department prior to early termination of a Special Needs Trust pursuant to Wyoming Statute § 4-10-412, and the Department shall be joined as a party to any such proceedings and served with a copy of all pleadings.~~ Penalties for transferred resources shall not apply to resources transferred into a Pooled Trust, except that all amounts transferred to the Pooled Trust by the beneficiary or beneficiary's spouse after the beneficiary turns age sixty-five (65) shall be subject to a transfer penalty as specified in subsection (h) below.

~~(V) The Department is a Qualified Beneficiary pursuant to Wyoming Statute § 4-10-103 and shall consent to termination of a Special Needs Trust pursuant to Wyoming Statutes §§ 4-10-412 and 4-10-415 prior to death when a court order is entered providing that the Department shall be fully reimbursed from the Special Needs Trust.~~

~~(VI) Distributions.~~

(1.) Distributions from the Special Needs Trust shall be for the sole benefit of the disabled individual and shall be used to provide for the individual's special needs.

(2.) Distributions for funeral expenses shall not be paid after the beneficiary's death until the Department and all other state Medicaid agencies are fully reimbursed.

(3.) Distribution for basic needs shall only be allowed when the Trustee has proven to the Department that the disabled individual's basic needs are not adequately being provided for by government assistance programs.

(VII) Contributions. All contributions from third parties to the trust shall be deemed a completed gift to the disabled individual, and the third party may not obtain a refund, redirect resources transferred to the trust, or otherwise exert any interest or control over the resources in the trust.

(VIII) Structured Settlements, Annuities. When the trust has been or will receive annuity payments, structured settlement payments, or any other periodic payments, the payments shall be titled in the name of the Special Needs Trust.

(IX) Accountings. The trustee shall provide an annual accounting of the trust income and expenditures. The Department may request more frequent accountings at its discretion.

(X) Income. All distributions to or for the benefit of the individual, unless paid directly to a third party, shall be income to the individual.

(XI) Principal. No portion of the principal shall be available to the individual.

(XII) Repayment to the Department and Final Accounting. When the individual beneficiary dies or the trust is terminated, the trustee shall notify the Department and provide a sworn affidavit and an accounting within two (2) months after the individual's death.

(D) Pooled Trusts shall be established in accordance with Wyoming Statute § 42-2-403(f)(iii) and Section 1917 of the Social Security Act.

(I) To qualify for a Pooled Trust exception and exclude the resources, including the principal within the trust, the pooled trust shall:

(1.) Be irrevocable;

(2.) Be established for the sole benefit of an individual who is under age sixty-five (65) and disabled according to the criteria set forth in 42

~~U.S.C. § 1382c(a)(3), by the parent, grandparent, legal guardian of the disabled individual, by the disabled individual, or by a court;~~

~~(3.) Be established and managed by a non-profit association;~~

~~(4.) Maintain a separate account and Joinder Agreement for each beneficiary, but for the purposes of investment and management of funds, the accounts are pooled; and~~

~~(5.) Provide that to the extent that amounts remaining in a beneficiary's account upon the death of the individual beneficiary are not retained by the trust, the trust pays to the state from the remaining amount in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.~~

~~(II) Distributions. The pooled trust shall provide that all distributions shall be for the sole benefit of the disabled individual and shall be used to provide for the individual's special needs.~~

~~(1.) Any distribution from the trust paid directly to the disabled individual shall be considered available income.~~

~~(2.) Distributions for funeral expenses may not be paid after the beneficiary's death until the Department and all other state Medicaid agencies are fully reimbursed.~~

~~(III) Transfer Penalties. Penalties for transferred resources shall not apply to resources transferred into a Pooled Trust, except that all amounts transferred to the Pooled Trust by an individual or his spouse after age sixty-five (65) shall be subject to a transfer penalty as specified in subsection (h) below.~~

(vii) Real property shall be considered unavailable to the individual for purposes of resource determinations when:

(A) Bona Fide Effort To Sell Agreement when the client has been eligible for Medicaid for six months or more, or

(B) Conditional Benefits Agreement when the individual has been eligible for Medicaid for less than six months.

(e) ~~Special Circumstances. If an individual otherwise meets the criteria for the Comprehensive, Support or Acquired Brain Injury Waiver, but does not meet the income or resource requirements, the individual may retain waiver services through the Employed Individuals with Disabilities program.~~ Personal Care Contracts

~~(vii) Personal Care Contracts~~

~~(A) A "Personal Care Contract" (PCC) is an agreement between a caregiver and an aged, blind or disabled individual to provide caregiver services for fair market value. Payments made to family members through a PCC to delay or prevent entrance into a long term care facility are considered transfers for fair market value only if the agreement meets the requirements in this Section and documentation is provided to the Department upon request.~~

~~(B) The PCC shall be a detailed writing that includes:~~

~~(I) The date the care begins,~~

~~(II) A detailed description of the services to be provided,~~

~~(III) How often services will be provided,~~

~~(IV) How much the caregiver will be compensated,~~

~~(IV) When the caregiver will be compensated,~~

~~(V) How long the agreement is to be in effect,~~

~~(VI) A statement that the terms of the agreement can be modified only by mutual agreement of the parties,~~

~~(VII) The location where services will be provided, and~~

~~(VIII) The notarized signature of both parties.~~

~~(C) The following services may be provided through a PCC: preparing meals, shopping, medication management, transportation to medical appointments, paying bills, light housekeeping, and assistance with activities of daily living.~~

~~(I) Duplication of Services. No services shall be provided under a PCC while an individual resides in a long term care facility or receives services under a Waiver program. A caregiver shall not duplicate services provided by a home health aide, nurse, medical professional, or other care provider hired to assist the applicant or client regardless of whether the individual resides in a long term care facility or receives services within their home.~~

~~(II) "Advocating for services" shall not be an allowable service under a PCC.~~

~~(D) The Department shall verify the fair market value of these services~~

~~through the use of the U.S. Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook.~~

~~(E) The applicant or client shall submit detailed logs to clearly identify the services provided under the PCC. The logs shall include the date, time, amount paid, and services provided.~~

~~(F) Caregivers shall not receive payment in advance of services Performed. Prepayments made to caregivers shall be considered a transfer for less than fair market value.~~

~~(G) Caregivers receiving compensation under a PCC shall report compensation as income for tax purposes. Documentation of income reporting shall be provided to the Department upon request.~~

~~(H) Retroactivity. A PCC shall not be retroactive and shall be considered a transfer for less than fair market value in accordance with subsection (h) of this Chapter.~~

(i) A "Personal Care Contract" (PCC) is an agreement between a caregiver and an aged, blind or disabled individual to provide caregiver services for fair market value. Payments made to family members through a PCC to delay or prevent entrance into a long term care facility are considered transfers for fair market value only if the agreement meets the requirements in this Section and documentation is provided to the Department upon request.

(ii) The PCC shall be a detailed writing that includes:

(A) The date the care begins,

(B) A detailed description of the services to be provided,

(C) How often services will be provided,

(D) How much the caregiver will be compensated;

(E) When the caregiver will be compensated,

(F) How long the agreement is to be in effect,

(G) A statement that the terms of the agreement can be modified only by mutual agreement of the parties and approved by the Department,

(H) The location where services will be provided, and

(I) The notarized signature of both parties.

(iii) The following services may be provided through a PCC when the individual is receiving unduplicated services at home and are not in a facility: preparing meals, shopping, medication management, transportation to medical appointments, paying bills, light housekeeping, and assistance with activities of daily living.

(iv) No services shall be provided under a PCC while an individual resides in a long term care facility or receives services under a Waiver program. A caregiver shall not duplicate services provided by a home health aide, nurse, medical professional, or other care provider hired to assist the individual regardless of whether the individual resides in a long term care facility or receives services within their home.

(v) "Advocating for services" shall not be an allowable service under a PCC.

(vi) The Department shall verify the fair market value of these services through the use of the U.S. Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook see https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm?view_full.

(vii) Caregivers shall not receive payment in advance of services performed. Prepayments made to caregivers shall be considered a transfer for less than fair market value.

(viii) A PCC shall not be retroactive and shall be considered a transfer for less than fair market value in accordance with subsection (h) of this Chapter.

(f) Patient Contribution.

(i) Deductions from the client's gross income shall be allowed in determining the amount of the client's monthly contribution to be paid toward the cost of care in a medical facility.

(ii) Allowable deductions shall be applied in accordance with the Social Security Act, 42 C.F.R. ~~Chapter IV, Subchapter C, Part 435, Subpart I~~ 435.725 and the Medicaid State Plan.

(iii) An individual temporarily in an institution shall be allowed a maintenance deduction not to exceed one hundred fifty dollars ($150.00) per month for up to six (6) months to maintain the home, except:

(A) The deduction is not allowed when a physician verifies the ~~client~~ individual will not be able to return to the home within six (6) months; and

(B) The deduction is not allowed if the ~~client~~ individual has a spouse who is not institutionalized.

(iv) Deductions for a community spouse who lives in the community when the married partner lives in a medical institution, receives services under a Home & Community Based Services Waiver, or Hospice Care, shall be applied in the manner prescribed in Title XIX

of the Social Security Act, 42 C.F.R.. ~~Chapter IV, Subchapter. C, Part 435, Subpart I~~ 435.725 and the Medicaid State Plan.

(g) ~~Benefits.~~ Benefits begin:

(i) After completion of thirty (30) consecutive days in a medical institution or thirty (30) days after a hospice election. ~~Benefits begin the first day of the month of entry into the medical institution when all eligibility requirements are met~~

(ii) ~~Home and Community Based Services begin on t~~The first day of the month during which the plan of care is approved by the Department for the Home and Community Based Services Waiver Program, and after all eligibility requirements are met.

(h) Transfer penalties ~~are imposed as follows~~:

(i) A transfer penalty shall be imposed for nursing facility or home and community based services when an individual or the individual's spouse disposes of income or resources for less than fair market value on or after the look-back period, as prescribed in Section 1917(c) of the Social Security Act, 42 U.S.C. § 1396p(c), and Wyoming Statute § 42-2-402.

(A) ~~Fair Market Value means an estimate of the value of a resource if sold at the prevailing price at the time it was actually transferred.~~ It is presumed that a transfer for less than fair market value was made for the purpose of qualifying for Medicaid in the following circumstances.

(I) W~~hen determining the value of real property, fair market value shall be based on an appraisal or market analysis of the resource at the time of the sale or transfer of the property. The applicant or recipient has the obligation to provide the Department with an appraisal or market analysis. Failure to provide the requested documentation shall result in a denial of eligibility in accordance with Section 4(c)(iii) of this Chapter.~~ An inquiry about Medicaid benefits was made, by or on behalf of the individual, to any person before the date of the transfer, or;

(II) ~~For a resource to be considered transferred for fair market value or to be considered to be transferred for valuable consideration, the compensation received for the resource shall be in a tangible form with intrinsic value. A transfer for love and consideration is not considered a transfer at fair market value. Services provided for free at the time were intended to be provided without compensation.~~ A transfer was made by the individual or on the individual's behalf to a relative of the individual, a relative of the individual's spouse, or to the individual's fiduciary.

~~(1.) A transfer to a relative for care provided For free in the past is a transfer for less than fair market value. An individual can rebut this presumption with tangible evidence that is acceptable to the Department. Such evidence shall be in writing at the time services were provided to be considered by the Department.~~

(B) The fair market value of real property shall be based on an appraisal or market analysis of the property at the time of the sale or transfer of the property. The individual has the obligation to provide the Department with an appraisal or market analysis. Failure to provide the requested documentation shall result in a denial of eligibility.

(C) For a resource to be considered transferred for fair Market value or to be considered to be transferred for valuable consideration, the compensation received for the resource shall be in a tangible form with intrinsic value. A transfer for love and consideration is not considered a transfer at fair market value. Services provided for free at the time performed were intended to be provided without compensation.

(I) A transfer to a relative for care provided without compensation in the past is a transfer for less than fair market value.

(II) An individual can rebut this presumption with tangible evidence that is acceptable to the Department. Such evidence shall be in writing at the time services were provided to be considered by the Department.

(D) A transfer penalty shall be reduced in the amount of returned resources to the individual or paid directly to a provider on behalf of the individual. The amount of returned resources shall be determined using Fair Market Value.

(I) A return of resources to pay for attorney fees during a contested case shall not reduce the penalty period for the individual. Attorney fees are the sole responsibility of the individual.

(II) A request for an undue hardship shall be made in writing and include documentation to support and demonstrate an undue hardship in accordance with Section 8.

(E) Undue hardship will be considered if the transfer penalty would deprive the individual of food, clothing, shelter, or other necessities of life or medical care such that the individual's health or life would be endangered, verified with the Medicaid Hardship Exception Request and Physician Statement and one of the following has occurred:

(I) It is determined that the person who received the transferred resource cannot be located by the individual, the individual's spouse, the individual's fiduciary, or an agent of the nursing facility, after all attempts to locate the person have been exhausted; or

(II) The resource transferred was due to theft, fraud, or

financial exploitation of the individual or their spouse, which has been reported and pursued through Adult Protective Services or law enforcement; or

(III) The individual or their fiduciary has exhausted all reasonable legal means to recover or regain possession or obtain fair market value of the transferred resource or income. "Exhausting all reasonable legal means to recover" may include seeking the advice of an attorney and pursuing legal or equitable remedies, such as asset freezing, assignment, or injunction; seeking modification, avoidance, or nullification of a financial instrument, promissory note, mortgage, or other transfer agreement; cooperating with any attempt to recover the transferred asset; making a referral to Adult Protective Services; filing a police report; and seeking recovery through the court.

~~(ii) A transfer penalty shall be reduced in the amount of returned resources to the applicant or recipient. The amount of returned resources shall be determined using Fair Market Value, as defined in (h) of this Section.~~

~~(A) A return of resources to pay for attorney fees during a contested case shall not reduce the penalty period for the applicant or recipient. Attorney fees are the sole responsibility of the contestant under Chapter 4.~~

~~(iii) Undue hardship, as specified in Section 1917(c) of the Social Security Act, shall apply to transfer of resource penalties. Any request for an undue hardship shall be made in writing and include documentation to support and demonstrate an undue hardship in accordance with this Section.~~

~~(A.) It is presumed that a transfer for less than fair market value was made for the purpose of qualifying for Medicaid in the following circumstances.~~

~~(I) An inquiry about Medicaid benefits was made, by or on behalf of the individual, to any person before the date of the transfer, or~~

~~(II) A transfer was made by the individual or on the individual's behalf to a relative of the individual, a relative of the individual's spouse, or to the individual's fiduciary.~~

~~(1.) "Relative" means a parent, child, stepchild, grandparent, grandchild, brother, sister, stepbrother, stepsister, aunt, uncle, niece, nephew, whether by birth or adoption, and whether by whole or half-blood, of the individual or the individual's current or former spouse.~~

~~(2.) "Fiduciary" means an individual's attorney-in-fact, guardian, conservator, legal custodian, caretaker, trustee, attorney, accountant, or agent."~~

~~(B) Undue hardship will be considered if the transfer penalty would~~

~~deprive the individual of food, clothing, shelter, or other necessities of life or medical care such that the individual's health or life would be endangered and one of the following has occurred:~~

~~(I) It is determined that the receiving party cannot be located by the individual, the individual's spouse, the individual's fiduciary, or an agent of the nursing facility, after all attempts to locate the receiving party have been exhausted; or~~

~~(II) The resource transferred was due to theft, fraud, or financial exploitation of the individual or their spouse, which has been reported and pursued through Adult Protective Services or law enforcement; or~~

~~(III) The individual or their fiduciary has exhausted all reasonable legal means to recover or regain possession or obtain fair market value of the transferred resource or income.~~

~~(1.) "Exhausting all reasonable legal means to recover" may include seeking the advice of an attorney and pursuing legal or equitable remedies, such as asset freezing, assignment, or injunction; seeking modification, avoidance, or nullification of a financial instrument, promissory note, mortgage, or other transfer agreement; cooperating with any attempt to recover the transferred asset; making a referral to Adult Protective Services; filing a police report; and seeking recovery through the court.~~

~~(C) Undue hardship does not exist when:~~

~~(I) The applicant or client transferred the resource in order to qualify for Medicaid;~~

~~(II) The imposition of the transfer penalty is only an inconvenience or may restrict the applicant's lifestyle;~~

~~(III) The undoing of a transfer would cause adverse tax consequences, interest charges, or other contract damages;~~

~~(IV) The undoing of a transfer would cause hardship to an individual who is not the applicant or client; or~~

~~(V) The applicant or client does not meet the criteria as set forth in Subsection (B).~~

(i) ~~Reporting Changes. Clients~~ Individuals shall be responsible for reporting to the Department any changes in the following:

(i) Income;

(ii) Resources;

(iii) Household size;

(iv) Health insurance; and

(v) Address.

Section 9. ~~Special Eligibility Group.~~ Breast and Cervical Cancer Treatment Program.

(a) ~~Breast and Cervical Cancer Treatment Program.~~ The Department's Public Health Division's Breast and Cervical Cancer Early Detection Program identifies applicants in need of treatment for either breast or cervical cancer. Financial eligibility is determined by the Department's Division of Healthcare Financing or designee.

~~(i) The Department's Public Health Division's Breast and Cervical Cancer Early Detection Program identifies applicants in need of treatment for either breast or cervical cancer. Financial eligibility is determined by the Department's Division of Healthcare Financing or designee.~~

(b) ~~Treatment of Income.~~ Eligibility Requirements.

(i) Countable family income is less than or equal to two hundred and fifty percent (250%) of the Federal Poverty Level.

(ii) Income shall be calculated using the modified adjusted gross income of the household, as specified in 42 C.F.R. § 435.603 and the State Plan.

(iii) Individuals shall be under the age of 65.

(iv) Individuals shall not be eligible for Medicaid or have health insurance.

(v) Eligibility shall be reviewed by the Department for continued eligibility every twelve (12) months.

~~(c) Age Requirement. Individuals shall be under the age of 65.~~ Individuals shall be responsible for reporting to the Department any changes in the following:

(i) Income;

(ii) Health insurance;

(iii) Address; and

(iv) Conclusion of treatment

~~(d) Not eligible for Medicaid and has no health insurance.~~

~~(e) Review of Eligibility. Eligibility shall be reviewed by the Department for continued eligibility every twelve (12) months.~~

~~(f) Reporting Changes. Clients shall be responsible for reporting to the Department any changes in the following:~~

~~(i) Income;~~

~~(ii) Health insurance;~~

~~(iii) Address; and~~

~~(iv) Conclusion of treatment~~

Section 10. Employed Individuals with Disabilities Eligibility Group.

(a) Medicaid benefits are available to individuals with disabilities who work and pay a monthly premium for their healthcare coverage ~~as specified in Section 1902(a)(10)(A)(ii)(XV) of the Social Security Act. and 42 U.S.C. § 1396a(a)(10)~~.

(b) ~~Treatment of Income. Countable unearned income shall be less than or equal to three hundred percent (300%) of the Supplemental Security Income (SSI) payment standard.~~ Eligibility Requirements.

(i) Countable unearned income shall be less than or equal to three hundred percent (300%) of the Supplemental Security Income (SSI) payment standard.

(ii) Resource tests do not apply for this eligibility group.

(iii) Individuals shall be age sixteen (16) through sixty-four (64).

(iv) An individual shall be employed part-time or full-time during a specified payroll period. The individual can be considered employed when not working, but on temporary absence due to medical leave.

(v) The individual shall pay a monthly premium, as calculated according to W.S. §§ 42-4-115 and 42-4-116.

(vi) If an individual otherwise meets the criteria for the Comprehensive, Support or Acquired Brain Injury Waiver, but does not meet the income or resource requirements, the individual may retain waiver services through the Employed Individuals with Disabilities program.

(c) ~~Treatment of Resources. Resource tests do not apply for this eligibility group.~~ Individuals shall be responsible for reporting to the Department any changes in the following:

(i) Income;

(ii) Household size;

(iii) Health insurance; ~~and~~

(iv) Address; and

(v) Employment.

~~(d) Age Requirement. Individuals shall be age sixteen (16) through sixty-four (64).~~

~~(e) Employed. An individual shall be employed part-time or full-time during a specified payroll period. The individual can be considered employed when not working, but on temporary absence due to medical leave.~~

~~(f) Premium. The individual shall pay a monthly premium, as calculated according to Wyoming Statutes §§ 42-4-115 and 42-4-116.~~

~~(g) Reporting Changes. Clients shall be responsible for reporting to the Department any changes in the following:~~

~~(i) Income;~~

~~(ii) Household size;~~

~~(iii) Health insurance; and~~

~~(iv) Address; and~~

Section 11. Medicare Savings Programs.

(a) Qualified Medicare Beneficiary (QMB). Medicaid shall assist individuals eligible for QMB with paying their Medicare premiums, cost sharing and deductibles, as specified in Sections 1902(a)(10)(E)(i) and 1905(p)(1) of the Social Security Act. Individuals shall meet the following eligibility requirements:

(i) ~~Individuals shall be~~ ~~e~~Entitled to Medicare.

(ii) ~~Treatment of Income.~~ Countable income shall be equal to or less than one hundred percent (100%) of the Federal Poverty Level (FPL).

(iii) ~~Treatment of Resources.~~ Countable resources shall not exceed three (3) times the SSI resource limit, as adjusted annually by the increase in the consumer price index.

~~(iv) Benefits begin the first day of the following month after eligibility is determined.~~

(b) Specified Low-Income Medicare Beneficiary (SLMB). Medicaid shall assist individuals eligible for SLMB with paying their Medicare Part B premium, as specified in Section 1902(a)(10)(E)(iii) of the Social Security Act. Individuals shall meet the following eligibility requirements:

(i) ~~Individuals shall be~~ ~~e~~Entitled to Medicare.

(ii) ~~Treatment of Income.~~ Countable income shall be more than one hundred percent (100%) of the FPL but less than or equal to one hundred twenty percent (120%) of the FPL.

(iii) ~~Treatment of Resources.~~ Countable resources shall not exceed Three (3) times the SSI resource limit, as adjusted annually by the increase in the consumer price index.

(c) Qualified Individual (QI). Medicaid can assist eligible individuals with paying their Medicare premiums, as specified in Section 1902(a)(10)(E)(iv) of the Social Security Act. Individuals shall meet the following eligibility requirements:

(i) ~~Individuals shall be e~~Entitled to Medicare.

(ii) ~~Treatment of Income.~~ Countable income shall be more than one hundred twenty percent (120%) of the FPL but less than or equal to one hundred thirty-five percent (135%) of the FPL.

(iii) ~~Treatment of Resources.~~ Countable resources shall not exceed three (3) times the SSI resource limit, as adjusted annually by the increase in the consumer price index.

(d) ~~Review of Eligibility.~~ Eligibility shall be re-determined by the Department every twelve (12) months for all groups within this section.

(e) ~~Reporting Changes.~~ ~~Clients~~Individuals shall be responsible for reporting to the Department any changes in the following:

(i) Income;

(ii) Resources;

(iii) Household size;

(iv) Health insurance; and

(v) Address.

Section 12. Emergency Services. Applicants who are not citizens or nationals of the United States, but otherwise meet the eligibility requirements of the State Plan, are eligible for limited emergency services, as specified in 42 C.F.R. § 440.255. Applicants who do not meet the citizenship ~~and~~ or alienage requirements shall not be eligible for emergency services under the Nursing Home, Home and Community Based Services under a waiver pursuant to Section 1915(c) of the Social Security Act, Hospice, Presumptive Eligibility, Family Planning Waiver, EID, Breast and Cervical Cancer, and Tuberculosis programs.

Section 13. Delegation of Duties. The Department may delegate any of its duties under this rule to the Wyoming Attorney General, Health and Human Services ~~(HHS)~~, any other agency of the federal, state or local government, or a private entity which is capable of performing such functions, provided that the Department shall retain the authority to impose sanctions, recover overpayments or take any other final action authorized by this Chapter.

~~**Section 14. 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 15. Superseding effect**. This Chapter supersedes all prior rules or policy statements issued by the Department, including manuals and bulletins, which are inconsistent with this Chapter.~~

~~**Section 16. Severability**. If any portion of these rules is found invalid or unenforceable, the remainder shall continue in effect.~~

~~**Section 17. Incorporation by Reference.**~~

~~(a) For any code, standard, rule, or regulation incorporated by reference in these 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 Sections 4, 5, 6, and 7 of this Chapter is 42 C.F.R., Chapter IV, Subchapter C. Part 435, incorporated as of the effective date of this Chapter and can be found at http://www.ecfr.gov.

(ii) Referenced in Sections 4 and 8 of this Chapter is the Wyoming Medicaid State Plan, incorporated as of the effective date of this Chapter and can be found at https://health.wyo.gov/healthcarefin/medicaid/spa/.

(iii) Referenced in Sections 5 and 11 of this Chapter is 42 C.F.R. Chapter IV, Subchapter C, Part 440, incorporated as of the effective date of this Chapter and can be found at http://www.ecfr.gov.

(iv) Referenced in Sections 6 and 7 of this Chapter is 42 C.F.R. Chapter IV, Subchapter C, Part 433, incorporated as of the effective date of this Chapter and can be found at http://www.ecfr.gov.

(v) Referenced in Section 7 and 8 of this Chapter is 20 C.F.R. Chapter III, Part 416, incorporated as of the effective date of this Chapter and can be found at http://www.ecfr.gov.

(vi) Referenced in Section 4, 6, 7, 8, 9, 10, and 11 f this Chapter is Title XIX of the Social Security Act Grants to States for Medical Assistance Programs, incorporated as of the effective date of this Chapter and can be found at http://ssa.gov.

(vii) Referenced in Section 6 of this Chapter is 42 U.S.C. § 1382a, incorporated as of the effective date of this Chapter and can be found at http://ssa.gov

(viii) Referenced in Section 7 of this Chapter is 42 U.S.C. § 1382c, incorporated as of the effective date of this Chapter and can be found at http://ssa.gov.

(ix) Referenced in Section 6 of this Chapter is Section 1115A of the Social Security Act, incorporated as of the effective date of this Chapter and can be found at http://ssa.gov.

(x) Referenced in Section 7 of this Chapter is Section 1634 of the Social Security Act, incorporated as of the effective date of this Chapter and can be found at http://ssa.gov.

(xi) Referenced in Section 7 is 42 U.S.C. § 1396p, incorporated as of the effective date of this Chapter and can be found at http://ssa.gov.