

TITLE 42 - WELFARE

CHAPTER 1 - GENERAL PROVISIONS

ARTICLE 1 - IN GENERAL

42-1-101. Definitions; generally.

(a) As used in this title:

(i) "Applicant" means any person applying for benefits under programs provided pursuant to this title;

(ii) "Department" means the department of family services unless otherwise specified;

(iii) Repealed by Laws 1991, ch. 161, § 4.

(iv) "Field office" means each field office of the department located within each county or region of the state;

(v) "Recipient" means any person receiving benefits under programs provided pursuant to this title.

42-1-102. Conflict with federal laws.

(a) If any provision of this title or W.S. 14-2-1001 through 14-2-1008 is found to be in conflict with federal law or to come in conflict with federal law due to new federal enactments, the department shall:

(i) Follow the state rather than the federal law to the extent possible without incurring federal sanctions;

(ii) Seek any waivers from the federal government which appear to be appropriate and feasible to permit continued use of the provisions of state law;

(iii) Notify the joint labor, health and social services interim committee and the legislature of the conflict and the steps necessary to resolve the conflict; and

(iv) If necessary to avoid federal sanctions with significant adverse effects on the state or the people of Wyoming, implement the federal law until sixty (60) days after the end of the general or budget legislative session following the discovery of the conflict. This period may be extended by

the governor until sixty (60) days after the end of the next legislative session if a waiver request is pending before the appropriate federal agency at the start of a legislative session.

CHAPTER 2 - PUBLIC ASSISTANCE AND SOCIAL SERVICES

ARTICLE 1 - IN GENERAL

42-2-101. Short title.

This article may be cited as the "Wyoming Public Assistance and Social Services Act".

42-2-102. Definitions.

(a) Except as otherwise specifically provided, as used in this article:

(i) "Commodities" means foods donated or available for donation by the department;

(ii) "Coupon" means any coupon, stamp or other type of certificate provided for the purchase of eligible food as defined by the supplemental nutrition assistance program;

(iii) "Electronic benefit transfer" means a system for the supplemental nutrition assistance program as an alternative to issuing a supplemental nutrition assistance program card. An electronic benefit transfer system is a computer-based system in which the benefit authorization is received through a point of sale terminal. Eligible households utilize plastic cards in lieu of supplemental nutrition assistance program coupons to purchase food items at authorized food retailers. This type of benefit may also be used to issue other types of public welfare benefits;

(iv) "Supplemental nutrition assistance program benefit" means assistance provided by the supplemental nutrition assistance program to eligible households in the form of coupons, electronic benefit transfers or cash that are redeemable at federally approved food retailers;

(v) "Performance payment" means an amount payable to or on behalf of an eligible recipient;

(vi) "Public assistance" means financial assistance in the form of a performance payment, vendor payment, supplemental nutrition assistance program benefits or a payment under the minimum medical program;

(vii) "Public welfare benefit" means financial assistance provided to eligible persons in the form of a performance payment, vendor payment, supplemental nutrition assistance program benefit, electronic benefit transfer or cash. These benefits may be received from several state or federal welfare programs including:

- (A) Medicaid;
- (B) Repealed by Laws 2017, ch. 108, § 2.
- (C) Repealed by Laws 2017, ch. 108, § 2.
- (D) Low income energy assistance program;
- (E) Minimum medical program;
- (F) Child care program;
- (G) Personal opportunities with employment responsibilities (POWER);
- (H) Supplemental nutrition assistance program.

(viii) "Social services" mean services specifically authorized by the legislature, defined by the comprehensive social services plan of the department and provided or purchased in accordance with this act;

(ix) "Approved educational program" means any program at the University of Wyoming or a Wyoming community college leading to a baccalaureate, associate degree, or certificate at the school or a vocational program approved by the department, or other accredited educational program within Wyoming leading to a baccalaureate, associate degree or nationally recognized certification or license. The department, may, by rule and regulation specify particular courses of study or majors that do not generally lead to employment and are not approved educational programs.

42-2-103. Provision of assistance and services; duties of department; burial assistance; department of health state supplemental security income program.

(a) The department shall provide and administer programs for public assistance and social services in Wyoming to those individuals lacking sufficient income or resources to provide themselves or their families with a reasonable subsistence compatible with decency and health or with services necessary for their well-being.

(b) In carrying out subsection (a) of this section and except as provided under the Wyoming Medical Assistance and Services Act, the department shall:

(i) Repealed by Laws 2017, ch. 179, § 2.

(ii) Establish policies and standards for the provision of public assistance and social services in accordance with this article and federal law and regulation;

(iii) Except as otherwise provided by law, establish by rule and regulation payment amounts and service levels for public assistance and social services programs provided under this article based upon the financial condition of the individual applicant or recipient;

(iv) Supervise the expenditure of state funds and federal funds allocated to the state for purposes of providing public assistance and social services in such a manner as to ensure that, to the extent funds are available and authorized by the legislature, funds may be used in separate state-funded programs to:

(A) Use, to the extent practicable, state maintenance of effort funds in a separate state funded program to provide public assistance to eligible individuals who have exhausted their benefits under the federal temporary assistance to needy families block grant and are exempt from the five (5) year limitation under paragraph (e) (i) of this section;

(B) Repealed by Laws 2017, ch. 108, § 2.

(C) Allow an individual receiving assistance to attend school as provided by W.S. 42-2-109(a) provided the individual:

(I) Has completed an employment assessment conducted under department rule or regulation;

(II) Meets the income and resource eligibility requirements of the personal opportunities with employment responsibilities (POWER) program;

(III) Qualifies as a full-time student under W.S. 42-2-109(a)(ii)(A) and (C).

(v) Cooperate with and report to the United States department of health and human services and other federal agencies as necessary to qualify the state for federal funding for public assistance and social services and comply with federal law and regulations governing the administration and expenditure of federal funds allocated to the state;

(vi) Serve as an agent of the federal government in matters of mutual concern and in the administration of federal funds allocated to the state for public assistance and social services;

(vii) Cooperate with other agencies as necessary to administer this article;

(viii) Limit approved educational programs under paragraph (iv) of this subsection to educational courses not to exceed the baccalaureate level, or to one (1) vocational training program;

(ix) Amend the state plan submitted to the United States department of health and human services to provide that the state elects as authorized by section 402(1)(A)(ii) of P.L. 104-193 to define work as including all activities permitted under section 407 of P.L. 104-193 plus satisfactory full-time school attendance as defined by W.S. 42-2-109;

(x) To the extent funds are available and authorized by the legislature and if full-time students as defined by W.S. 42-2-109 are required by federal law or regulation to work in addition to attending school full-time, create a state funds only program using funds required for maintenance of effort to provide assistance to such students. Such a program shall take priority over other uses of the maintenance of effort funds available;

(xi) Not discriminate against married couples with one (1) or more dependent children applying for assistance, provided the department may maintain work requirements for married couples consistent with the federal requirements for work participation for two (2) parent families;

(xii) Provide benefits under the personal opportunities with employment responsibilities (POWER) program to permanent resident aliens lawfully admitted to the United States under the Immigration and Nationality Act, as allowed under section 402 of P.L. 104-193;

(xiii) Exempt individuals domiciled in Wyoming from the application of section 115, subsection (a) of P.L. 104-193 allowing payment of benefits under the personal opportunities with employment responsibilities program (POWER) and the supplemental nutrition assistance program;

(xiv) Promulgate and adopt rules and regulations necessary to carry out this article;

(xv) Subject to the availability of funds, provide to recipients in an approved education program under W.S. 42-2-109(a) at least two (2) hours of dependent day care, if needed, for each hour the applicant is required to be in class, laboratory or other required instructional activity;

(xvi) Conduct the eligibility and identity verification process as provided in W.S. 42-10-101 through 42-10-107.

Note: Effective 1/1/2027 this paragraph will read as:

(xvi) Conduct the applicable eligibility and identity verification process as provided in W.S. 42-10-101 through 42-10-110.

(c) Notwithstanding any other provision of this article and subject to the availability of funds, the department shall pay the burial or cremation expenses of any recipient of aid under the personal opportunities with employment responsibilities (POWER) program, supplemental security income or Medicaid at the time of his death and without sufficient means in his own estate or other resources to provide burial or cremation. The amount paid under this subsection shall not exceed one thousand five hundred dollars (\$1,500.00) after consideration of funds available to the recipient from all other

sources. In addition to the amount paid for burial or cremation under this subsection, an amount shall be paid for transportation expenses to the veteran's cemetery for a deceased veteran who qualifies for burial there and who qualifies for burial expenses under this subsection in an amount not to exceed five hundred dollars (\$500.00). In determining eligibility under this subsection, the department shall not consider as available funds, an amount up to or equal to one thousand five hundred dollars (\$1,500.00) of the corpus of a Medicaid qualifying trust meeting the requirements of W.S. 42-4-113. No board of county commissioners shall be responsible for any burial or cremation expenses in excess of the amount paid under this subsection. Burial or cremation expenses under this subsection shall not include those expenses relating to cemetery costs.

(d) The department of health shall, by rule, administer a state supplemental security income program entitling any individual receiving payments under the federal supplemental security income program with no other income during any one (1) calendar month, to a payment for each month the condition exists. The monthly payment under this subsection shall be established by the legislature within the department of health's biennial budget appropriation, which shall not be less than the required payment under applicable federal law. Rules promulgated in accordance with this subsection shall include procedures for applying, approving, reviewing and terminating assistance under this subsection. Decisions of the department of health under this subsection regarding entitlement to payments shall be subject to the contested case procedures of the Wyoming Administrative Procedure Act.

(e) In administering this section and in addition to other requirements imposed under this chapter and the Wyoming Medical Assistance and Services Act and federal rule and regulation, the department shall by rule and regulation:

(i) Limit assistance payable under W.S. 42-2-104 to five (5) years for any assistance unit within a lifetime, regardless of location. Time spent on assistance funded with federal funds and time spent on assistance funded with state funds, shall be added together in determining the time spent on assistance for the purposes of this section. Adults who previously received assistance as a dependent child, excluding minor parents, shall be allowed up to the five (5) year lifetime limit under their own assistance unit. For minor parents only, one (1) year in the personal opportunities with employment responsibilities (POWER) program prior to reaching the age of

majority shall be counted against the five (5) year lifetime limit. Months of assistance received for an eligible dependent child by a nonparent caretaker relative who is not included in the calculation of the performance payment to the dependent child shall not count toward the nonparent caretaker relative's lifetime limit. Individuals who have received assistance under W.S. 42-2-104 for three (3) or more years as of January 1, 1997, shall be eligible for two (2) additional years of assistance used after January 1, 1997. Any individual who is totally physically or mentally disabled as specified by department rules, or who is a caretaker and stays at home to provide full-time care for a totally disabled or incapacitated immediate family member who resides with the caretaker because no other reasonable alternative, as determined by the department, is available to provide care and who otherwise qualifies for assistance under W.S. 42-2-104 shall not be subject to the limitation imposed under this paragraph. For an individual who is such a caretaker, the department shall waive any work requirements that unduly interfere with the provision of care and may waive other program requirements as appropriate. For purposes of this section an individual is totally disabled or incapacitated if he has a physical or mental impairment to the extent that it prevents the individual from achieving independent living, full-time employment, or participation in job training programs that will reasonably lead to independent living and monetary self sufficiency. The department may consult a licensed physician or other appropriate professional to make its determination of disability or incapacitation. Nothing in this paragraph shall prohibit the department from requiring recipients to maintain, improve or enhance employment and self-sufficiency efforts and activities. The department shall waive time limits, and may waive other program requirements as provided in paragraph (viii) of this subsection, as allowed under sections 402(a)(7)(A)(iii) and 408(a)(7)(A)(iii) of the federal Social Security Act, as amended by P.L. 104-193, for a period not to exceed two (2) years for individuals who are fleeing for personal safety or for the safety of their children or who have been victimized by domestic violence or who are at risk of further domestic violence. The department may extend assistance up to one (1) year under either the federal or state program in addition to the five (5) year limitation imposed under this paragraph for the following reasons:

(A) Repealed by Laws 1997, ch. 196, § 2.

(B) Continuation of education leading toward an associate or a baccalaureate degree under the state funded program only;

(C) Abandonment.

(ii) Require an unmarried parent under the age of eighteen (18) and the dependent child of the minor parent to reside in the household of a parent or in a supervised setting with an adult relative or court appointed guardian or custodian in order to qualify for assistance under W.S. 42-2-104, unless the minor parent is emancipated under law. Assistance under this paragraph shall be payable to the parent, relative or court appointed guardian or custodian on behalf of the minor parent and the dependent child. The income and resources of the parents shall be considered in determining eligibility for assistance under W.S. 42-2-104. If the minor custodial parent is living with a qualified person other than a parent and except for exemptions specified by department rule and regulation, the department shall through local child support enforcement agencies, enforce child support obligations of the parents of each minor parent, including the parents of the noncustodial minor parent. The department shall waive the requirements of this subsection if the only available households contain an individual who has been convicted of violating W.S. 6-4-402 or who has been charged with violating W.S. 6-4-402 and the charges have not received final disposition. The department shall assist law enforcement officials and the family of a minor mother to pursue the filing of criminal charges against the father of the minor mother's child if the minor mother conceived her child while under sixteen (16) years of age and the father was at least four (4) years older than the minor mother at the time of conception;

(iii) Limit assistance payable under W.S. 42-2-104 for the year 2008 as follows:

Family Size	Cumulative Inflation Factor	Maximum POWER Payment
1	1.489	\$290
2	1.489	476
3	1.489	506

4	1.489	506
5	1.489	536
6	1.489	536
7 and above	1.489	566

Beginning July 1, 2009 and annually thereafter, the maximum payment level shall be adjusted for the percentage change in the Wyoming cost-of-living index for the previous fiscal year as determined by the division of economic analysis of the department of administration and information.

(iv) Establish only one (1) earned income disregard for determining assistance payable under W.S. 42-2-104 at six hundred dollars (\$600.00) per month for any one (1) recipient. For married couples the earned income disregard shall be one thousand two hundred dollars (\$1,200.00) per month. The department may in addition establish an additional individual earned income disregard tailored to the individual person as part of that person's self-sufficiency plan developed pursuant to paragraph (v) of this subsection, provided:

(A) Such an individual earned income disregard shall be available only during time periods when the person is working at paid employment enough average number of hours per week to qualify as working for the purposes of section 407 of P.L. 104-193;

(B) The amount disregarded shall not exceed six dollars and fifty cents (\$6.50) per hour except that in high cost of living areas as defined by the department it shall not exceed seven dollars and fifty cents (\$7.50) per hour;

(C) The disregard shall be structured to allow one-half (1/2) of the person's preemployment personal opportunities with employment responsibilities (POWER) grant for a period not to exceed six (6) months and one-quarter (1/4) of the personal opportunities with employment responsibilities (POWER) grant for an additional period not to exceed six (6) months;

(D) The one-half (1/2) grant in the first period may be paid from either state funds or federal funds and shall count toward the five (5) year limit established by W.S. 42-2-103(e). The one-quarter (1/4) grant in the second period shall

be paid from state maintenance of effort funds and shall not be subject to the time limits established by W.S. 42-2-103(e);

(E) The use of the individual earned income disregard may be conditioned upon successful completion of other portions of the person's self-sufficiency plan;

(F) The decision to allow an individual earned income disregard in a particular case is discretionary with the department and the department's decision is not subject to judicial review;

(G) The individual earned income disregard shall be used only to the extent the department determines funds are available and are not needed for other purposes with higher priority.

(v) In accordance with guidelines and criteria prescribed by rule and regulation of the department and unless otherwise qualifying for a good cause exemption pursuant to rule and regulation of the department, require the development of and adherence to a self-sufficiency plan with guidelines and assistance provided by the department, as a condition for benefit eligibility under the personal opportunities with employment responsibilities (POWER) program. A self-sufficiency plan including timely completion of an approved educational program complying with W.S. 42-2-109(a) shall be deemed to meet the requirements of this subsection if adhered to. Any person not qualifying for a good cause exemption and failing to comply with this paragraph shall be sanctioned under the personal opportunities with employment responsibilities (POWER) program. Subject to procedure prescribed by department regulation, any recipient may at any time request a good cause exemption from the requirements of this section;

(vi) Impose time limitations on educational goals of recipients of assistance under W.S. 42-2-104 who are under twenty (20) years of age and have not obtained a high school diploma or general equivalency degree;

(vii) Require that applicants and current recipients cooperate within a period specified by department rules to establish paternity and child support obligations, subject to good cause exceptions established by department rules and regulations. The applicant shall not be eligible for personal opportunities with employment responsibilities benefits and a

recipient shall not receive benefits until the applicant or recipient has cooperated as required under this paragraph;

(viii) Provide that the department may waive program requirements, other than time limits which shall be waived under paragraph (i) of this subsection, for individuals who are fleeing for personal safety or for the safety of their children or who have been victimized by domestic violence, or who are at risk of further domestic violence, as follows:

(A) Work participation requirements or state postsecondary education program restrictions may be waived for one (1) year, without re-evaluation, for individuals who have not exhausted their benefits under the federal temporary assistance to needy families block grant. Program requirements under this paragraph may not be waived for longer than:

(I) One (1) year, unless the recipient's circumstances are re-evaluated at six (6) month intervals after the first year;

(II) Two (2) years, unless the recipient meets the requirements of subdivision (I) of this subparagraph and is cooperating in the development and implementation of a plan with the department and the local domestic violence agency to correct circumstances which have contributed to the domestic violence or the threat of domestic violence.

(B) For individuals who have exhausted their benefits under the federal temporary assistance to needy families block grant, program requirements under this paragraph may be waived by the department only if the individual's circumstances are re-evaluated at six (6) month intervals and, after one (1) year, the individual is cooperating in the development and implementation of a plan with the department and the local domestic violence agency to correct circumstances which have contributed to the domestic violence or threat of domestic violence.

(f) In administering the child care and development fund provided for in the federal Child Care and Development Block Grant Act, and subject to approval of a state plan amendment by the administration of children and families of the United States department of health and human services, the department shall:

(i) Annually by April 1 establish the hourly copayment required to be paid by parents for each eligible child, subject to the following:

(A) Households with income at or below one hundred percent (100%) of the federal poverty level shall not be required to make a copayment;

(B) For households with income above one hundred percent (100%) up to two hundred twenty-five percent (225%) of the federal poverty level, the copayment shall be calculated based on the following table. For each category of income in the first column, the parents' hourly copayment per child shall be determined by multiplying the annual income dollar amount for a family of two (2) that corresponds with the percentage of federal poverty level in the second column by the multiplier in the third column, then dividing by two thousand three hundred forty (2,340), the annual number of hours of child care required by a full-time working parent, and rounding the result to the nearest five cents (\$.05):

Household Category of Income	Federal Poverty Level	Income Factor Multiplier
101% - 125%	113%	1.25%
126% - 150%	138%	2.00%
151% - 175%	163%	7%
176% - 200%	188%	9%
201% - 225%	213%	12%

(C) In determining eligibility, the department shall use the most recent federal poverty guidelines for the applicant's household size and income. In determining the hourly copayment for each eligible child, the department shall use the appropriate category of income in which the household qualifies;

(D) If the department determines that funding will be inadequate to implement the child care and development fund for the balance of the appropriation period, the department may increase copayments as calculated by subparagraph (B) of this paragraph by ten percent (10%) for households whose income

is less than two hundred percent (200%) of the federal poverty level and by twenty percent (20%) for households whose income is equal to or above two hundred percent (200%) of the federal poverty level.

(ii) From funds available under the American Recovery and Reinvestment Act of 2009, any funds not needed for completion of the electronic benefit transfer system shall be used to make grants for materials and supplies to child care facilities, provided however that a facility receiving a grant shall agree in writing to provide not less than twenty-five percent (25%) of the facility's available care to persons determined eligible under paragraph (i) of this subsection, for a period commensurate with the amount of the grant as determined by rule and regulation of the department, or to repay any monies granted under this paragraph to the state of Wyoming plus interest at the rate of ten percent (10%) per annum;

(iii) If the department determines that eligibility for other social services programs changes in ways that require a change in the formula provided by paragraph (i) of this subsection, the department shall report the change together with recommended legislation to the joint labor health and social services interim committee.

42-2-104. Personal opportunities with employment responsibilities; provision; eligibility; unemployed parent program.

(a) The department may through the personal opportunities with employment responsibilities (POWER) program provide financial assistance for a dependent child and an eligible caretaker. Financial assistance under this program shall be in the form of a performance payment or protective payment payable to or on behalf of an eligible recipient. Any individual not a relative of the dependent child but interested in or concerned with the welfare of the child and his eligible caretaker may subject to qualifications prescribed by rule and regulation of the department, receive a protective payment on behalf of the dependent child which shall not count toward the caretaker's five (5) year limit for benefits under W.S. 42-2-103(e) (i) unless the nonrelative caretaker is included in the calculation of the performance payment of the dependent child.

(b) In addition to any other state or federal regulation and subject to W.S. 42-2-103(e), an assistance unit qualifying under W.S. 42-2-103(a) with a dependent child is eligible for

financial assistance under the personal opportunities with employment responsibilities (POWER) program. For purposes of this subsection, a dependent child includes any child who is under eighteen (18) years of age and living with a relative in a residence maintained by the relative as determined by rule and regulation of the department, regularly attending school or its equivalent as determined by the department, or is expected to graduate from high school before the age of nineteen (19) years. For purposes of this subsection, a dependent child does not include a minor parent.

(i) Repealed By Laws 1997, ch. 196, § 2.

(ii) Repealed By Laws 1997, ch. 196, § 2.

(c) Repealed By Laws 1997, ch. 196, § 2.

(d) Subject to the availability of funds, the department may by rule and regulation create a program to provide financial assistance to assistance units in which there is a dependent child and both of the parents are unemployed.

42-2-105. Application for assistance and services; investigation of applicant.

(a) An individual or other person on his behalf may apply in writing for public assistance and social services under this article to the field office of the department located within the county or region in which the individual resides. A relative or other person interested in the welfare of a dependent child and his family may apply for the child. Application shall be upon a form and in a manner prescribed by rule and regulation of the department.

(b) Upon receipt of an application under subsection (a) of this section, the department shall investigate the facts stated in the application and obtain necessary information to determine eligibility for public assistance and social services.

42-2-106. Approval or disapproval of application; notification of applicant; amount and form of assistance and services.

(a) Based upon the eligibility of an applicant, the department shall approve or disapprove each application for public assistance or social services filed with its field offices pursuant to W.S. 42-2-105 and shall notify the applicant

of its decision. Eligibility determinations for public assistance under this chapter shall be made separately from eligibility determinations for medical assistance under Title XIX of the federal Social Security Act.

(b) Upon approval and in accordance with this article and its rules and regulations, the department shall determine the form, amount and commencement date of public assistance and social services for each approved application. In determining the amount of public assistance and social services for applicants who receive a housing subsidy, for households with a supplemental security income recipient or for unmarried minor parent applicants, the department shall take into consideration the supplied shelter tables as established in its rules and regulations.

(c) In any assistance program under this chapter for which income is the criterion or one (1) of the criteria for assistance payments, compensation received for a veteran's service connected disability shall not be counted in determining income if that compensation on an annual basis is not more than the poverty level for the applicant as determined by the federal office of management and budget.

(d) When the department approves an application for public assistance under the personal opportunities with employment responsibilities (POWER) program, it shall inform the approved applicant of the opportunity to continue to receive benefits under the program while participating in an approved educational program, provided the person is accepted into the approved educational program and otherwise continues to meet eligibility requirements of both programs.

42-2-107. Payment of assistance; custodian for incompetent recipients.

(a) Public assistance and social services approved under this article:

(i) May be provided in the form of a performance payment or other financial assistance, in the home of the applicant, in an institution or in any other manner or form determined appropriate by rule and regulation of the department;

(ii) Shall be provided to the recipient until terminated or modified pursuant to this article;

(iii) Shall be provided to qualified recipients who move to Wyoming from other states, except the amount of the performance payment or other financial assistance for the first twelve (12) months of eligibility in Wyoming may, at the option of the department, be the lesser of:

(A) The amount of assistance for which the recipient would be entitled in Wyoming; or

(B) The amount of the assistance the recipient would be receiving in the state of prior residence.

(b) A performance payment or any other form of public assistance shall be payable to the recipient or to a custodian or a vendor on behalf of the recipient. If the recipient is determined incompetent for purposes of using the public assistance provided under this article in the most beneficial manner, the amount may be payable to a custodian of the recipient. Subject to approval of the department, the custodian may receive and dispose of the public assistance on behalf of the recipient and shall report quarterly to the department providing a detailed accounting of his management of the amounts received under this subsection. The department shall review the report, determine if the conduct of the custodian is in the best interests of the recipient and file a copy of the report in the recipient's case record.

42-2-108. Continuous assistance to recipient changing residence to another county; assistance provided to nonresidents; termination upon leaving state.

(a) The department shall provide for the continuous and uninterrupted receipt of approved public assistance and social services by any eligible recipient changing his residence from one (1) county to another county in the state until otherwise terminated or modified in accordance with this article.

(b) Any transient or nonresident of the state may receive public assistance or social services provided under this article if approved in accordance with this article. The department may require the transient or nonresident to pay his transportation and expenses if he possesses property, income or other resources other than personal effects necessary for decency and health.

(c) Public assistance or social services shall be terminated in the manner prescribed by rule and regulation of the department for any recipient moving to another state.

42-2-109. Review of assistance and services; termination or modification; notice to department of change in assets.

(a) Public assistance and social services provided under this article shall be reviewed at least once each year, except for recipients enrolled in an approved educational program which shall be reviewed once every six (6) months. An approved educational program under this section shall be limited to educational courses not to exceed the baccalaureate degree level. After review, the department may continue, modify or terminate public assistance and social services in accordance with the circumstances of the recipient and the provisions of this article. Review of recipients in an approved educational program pursuant to this subsection shall require that recipients:

(i) To maintain a "C" or equivalent cumulative grade point average in the approved educational program;

(ii) Be enrolled as a full-time student, provided:

(A) To qualify as a full-time student under this paragraph, the student shall be enrolled for a minimum of twelve (12) credit hours per semester or activities that equal twelve (12) credit hours as defined by the institution and complete twenty-four (24) or more credit hours per year or activities that equal twenty-four (24) credit hours per year as defined by the institution in an approved educational program;

(B) A full-time student qualifying under this paragraph is exempt from any work or community service requirement under this article, except as provided in paragraph (iii) of this subsection;

(C) To qualify under this paragraph, the full-time student shall be a Wyoming resident in accordance with guidelines and criteria prescribed by rule and regulation of the department.

(iii) From the end of the spring semester to the beginning of the fall semester, work at least thirty-two (32) hours per week for at least ten (10) weeks or successfully complete six (6) credit hours. The department may waive this requirement for good cause.

(iv) Repealed by Laws 2005, ch. 238, § 2.

(b) Upon gaining possession of any property, income or other assets after receiving any public assistance and social services under this article, a recipient shall notify the department not later than ten (10) calendar days after becoming aware of the change in circumstances. The amount of public assistance and social services provided to the recipient shall be accordingly terminated or modified pursuant to rule and regulation of the department. The department shall exempt not more than two (2) licensed motor vehicles from personal assets in determining eligibility for any household under the personal opportunities with employment responsibilities (POWER) program.

(c) Repealed By Laws 1997, ch. 196, § 2.

42-2-110. Administrative and judicial review.

(a) An applicant or recipient whose application is not acted upon within a reasonable time following the date of application or who is aggrieved by any determination for the provision, amount, modification or termination of public assistance and social services under this article may appeal to the department in a manner and form prescribed by the department. The department shall provide the applicant or recipient reasonable notice in accordance with its rules and regulations and shall provide opportunity for hearing pursuant to the Wyoming Administrative Procedure Act. Following conclusion of the hearing, the department shall render a final decision.

(b) A decision of the department may be appealed to the district court as provided by the Wyoming Administrative Procedure Act.

42-2-111. Prohibited disclosure and use of records; penalty; judicial discovery.

(a) Except as provided in this section, no person shall disclose, receive, use or knowingly permit or participate in the use of any information derived from records maintained pursuant to law or acquired in the performance of duties under this article for purposes not directly related to the administration of this article.

(b) A violation of subsection (a) of this section is a misdemeanor.

(c) In accordance with the Wyoming Rules of Civil Procedure, any county or district court may subpoena the records maintained under this article and require the testimony of personnel involved in the administration of this article which is pertinent to any proceeding involving the:

(i) Custody, welfare or interest of any minor receiving public assistance and social services under this article;

(ii) Termination of parental rights as provided by law;

(iii) Prosecution of any person for a crime connected with obtaining public assistance and social services;

(iv) Foreclosure of liens held by the department.

(d) Upon request of a federal, state or local law enforcement officer as defined by federal statute and W.S. 9-1-701(a)(vi), the department may furnish the requesting officer the current address of any recipient under the personal opportunities with employment responsibilities (POWER) program if the requesting officer:

(i) Furnishes the department with the name of the recipient; and

(ii) Notifies the department that the recipient:

(A) Is a fleeing felon as described in paragraph (iii) of this subsection or has information necessary for the requesting officer to conduct the officer's official duties; and

(B) The location or apprehension of the recipient is within the requesting officer's duties.

(iii) For purposes of this section, a fleeing felon is defined as an individual who:

(A) Is fleeing to avoid prosecution, custody or confinement after conviction, under the laws of the jurisdiction from which the individual flees, for a crime or attempt to commit a crime, which is a felony under the laws of the jurisdiction from which the individual flees, or which, in the case of the state of New Jersey, is a high misdemeanor, or is

violating a condition of probation or parole imposed under federal or state law; and

(B) Whose conduct as described in this subsection has not been pardoned by the president of the United States or the governor of the jurisdiction from which the felon flees.

(e) If the department learns of the location of a fleeing felon or of an individual who has an outstanding warrant for his arrest, the department shall notify the appropriate law enforcement agency. The department shall limit disclosure under this section by providing only the current address of the recipient under the personal opportunities with employment responsibilities (POWER) program.

42-2-112. Misrepresentation; penalties; recovery, termination or modification of assistance and services.

(a) No person shall knowingly make a false statement or misrepresentation, fail to disclose a material fact, aid, abet or conspire with any other person in obtaining any form of supplemental nutrition assistance benefit under the supplemental nutrition assistance program.

(b) No person shall knowingly make a false statement or misrepresentation, fail to disclose a material fact, aid, abet or conspire with any other person in obtaining any commodity under the supplemental nutrition assistance program.

(c) No person shall knowingly trade or otherwise dispose of any supplemental nutrition assistance benefit received under the supplemental nutrition assistance program, except to a federally authorized food retailer.

(d) No person shall knowingly sell any form of supplemental nutrition assistance benefit to any other person.

(e) No person shall knowingly give, sell, trade or otherwise dispose of any commodity obtained under the supplemental nutrition assistance program to any other person.

(f) No person shall knowingly buy, trade or otherwise obtain any form of supplemental nutrition assistance benefit from any other person, except as authorized by law.

(g) No person shall knowingly buy, trade or otherwise obtain any commodity under the supplemental nutrition assistance program from any other person, except as authorized by law.

(h) No person shall knowingly make a false statement or misrepresentation, knowingly fail to disclose a material fact, aid, abet or conspire with any other person in obtaining public welfare benefits.

(j) No person shall knowingly directly or indirectly deprive himself of any property, income or other resources in order to qualify for public welfare benefits.

(k) Any person violating this section is guilty of:

(i) A felony punishable by imprisonment for not more than ten (10) years, a fine of not more than ten thousand dollars (\$10,000.00), or both, if the value of the commodity, supplemental nutrition assistance benefit or other public welfare benefit under this article is five hundred dollars (\$500.00) or more; or

(ii) A misdemeanor punishable by imprisonment for not more than six (6) months, a fine of not more than seven hundred fifty dollars (\$750.00), or both, if the value of the commodity, supplemental nutrition assistance benefit or other public welfare benefit under this article is less than five hundred dollars (\$500.00).

(m) In addition to the penalty imposed under subsection (k) of this section, the amount of public welfare benefits improperly provided due to any violation of this section may be recovered by appropriate action which shall be instituted by the department or by the attorney general on behalf of the department.

(n) The department shall disapprove, terminate or modify the public welfare benefits to any applicant or recipient who has been found guilty of violating this section until any court sentence under this section is completed and full restitution is made to the department. Public welfare benefits shall not be denied to any minor because of violation of this section by a parent or guardian.

42-2-113. Assignment or transfer of assistance and services; exemption from legal process.

(a) Any assignment or transfer of public assistance and social services provided under this article is void.

(b) Except as authorized under W.S. 42-2-112(m), public assistance and social services provided by this article are exempt from levy, execution, attachment, garnishment or other legal process or debt collection remedy. A waiver of exemptions provided by this subsection is void.

42-2-114. Reimbursement of federal government.

The department shall reimburse the federal government as required by federal law.

42-2-115. Supplemental nutrition assistance program eligibility recertification frequency. Note: this section is effective as of 1/1/2027.

(a) *The department shall assign certification periods of not greater than four (4) months to households that include an able bodied adult without dependents and other households whose circumstances are determined by the department to be unstable, unless otherwise prohibited under federal law for the supplemental nutrition assistance program.*

(b) *The department shall assign certification periods of one (1) or two (2) months to households that the department determines will become ineligible for the supplemental nutrition assistance program in the near future, unless otherwise prohibited under federal law.*

(c) *Except as provided by subsections (a) and (b) of this section, the department shall assign certification periods of not more than six (6) months to households whose members are not elderly or disabled, unless otherwise prohibited under federal law.*

ARTICLE 2 - EMPLOYMENT AND TRAINING PROGRAM

42-2-201. Definitions.

(a) As used in this article:

(i) "Program" means the employment and training program created under this article;

(ii) "Support services" includes transportation, child care and other services necessary to enable participants in the program to participate without hardship to themselves or their families.

42-2-202. Participation required; exemptions; disqualification of benefits.

(a) If available within the county of his residence, any person receiving benefits from the department under the supplemental nutrition assistance or personal opportunities with employment responsibilities (POWER) programs shall as a condition of receiving any benefits, participate in the employment and training program unless he:

(i) Is not physically able to work;

(ii) Is determined to be unemployable by an employment assessment conducted pursuant to department rule or regulation; or

(iii) Qualifies for a good cause exemption under rule and regulation of the department.

(b) Any person not exempt under this section and failing to participate in the program as required under this article may be disqualified from receiving benefits under the supplemental nutrition assistance or personal opportunities with employment responsibilities (POWER) programs. A good cause exemption may be requested at any time by a benefit recipient.

(c) Notwithstanding any other provisions of this title all nonexempt recipients under the personal opportunities with employment responsibilities (POWER) program in the state shall be required to work or perform community service as defined by rules and regulations of the department subject to coordination with the United States department of health and human services if required. Recipients may be exempted from the requirement under this subsection if one (1) of the nonexempt recipients within the assistance unit:

(i) Repealed By Laws 1997, ch. 196, § 2.

(ii) Repealed By Laws 1997, ch. 196, § 2.

(iii) Except as provided in paragraph (c)(iv) of this section, has a child who has not attained the age of three (3) months;

(iv) Gives birth to a child after ten (10) months as a recipient under the personal opportunities with employment responsibilities (POWER) program. The recipient under this paragraph shall be exempted from the requirements under this section for a period of three (3) months after the child is born, unless the parent is a minor child in which case the recipient shall be required to attend school in accordance with paragraph (v) of this subsection;

(v) Is a minor child who is required to attend school pursuant to W.S. 21-4-102; or

(vi) For other good cause as determined by the department.

(d) Benefits and eligibility requirements under the personal opportunities with employment responsibilities (POWER) program shall be modified for assistance units under subsection (c) of this section as follows:

(i) Assistance units complying with subsection (c) of this section shall receive full benefits to which they are otherwise entitled under this title;

(ii) In an assistance unit having a minor who has completed the eighth grade or has attained sixteen (16) years of age, but has not yet graduated from high school and refuses to attend school or accept suitable employment if the parent will not cooperate with the appropriate authorities as specified in a plan approved by the department to resolve the problem, the assistance unit shall not receive a performance payment for any month the minor refuses to attend school or accept suitable employment;

(iii) Monthly earned income of a dependent full-time student up to the age of eighteen (18), excluding minor parents, shall not be included as income and resources in determining the eligibility of the assistance unit for assistance and the amount of assistance while the student is living in the residence of his caretaker relative;

(iv) In assistance units in which recipients not otherwise exempted from the requirements of subsection (c) of

this section, the assistance unit shall not receive a performance payment for any month the recipient fails to comply with subsection (c) of this section and the recipient shall not be eligible for medical assistance under chapter 4 of this title until the recipient complies with the provisions of this section;

(v) Excluding allowance for personal motor vehicles as specified under W.S. 42-2-109(b), the amount of assets an assistance unit may own shall be not greater than five thousand dollars (\$5,000.00).

42-2-203. Establishment of program; powers and duties of division.

(a) The department shall:

(i) Establish an employment and training program which shall include job registration and may include job search employment training, work experience and support services;

(ii) Establish the program in as many counties as is feasible given funding limitations, cost effectiveness, geography and unemployment in the county;

(iii) Enter into cooperative agreements with other agencies providing employment training and experience programs to prevent duplication;

(iv) Repealed by Laws 2017, ch. 179, § 2.

(v) Provide participants a copy of the rules and regulations promulgated by the department for the program on participation and for fair hearings.

(b) The department may contract with public agencies and private entities to implement this article. The department may promulgate rules and regulations to implement this article.

ARTICLE 3 - TELEPHONE ASSISTANCE PROGRAM

42-2-301. Repealed by Laws 2015, ch. 54, § 2.

42-2-302. Repealed by Laws 2015, ch. 54, § 2.

42-2-303. Repealed by Laws 2015, ch. 54, § 2.

ARTICLE 4 - MEDICAID ELIGIBILITY

42-2-401. Definitions.

(a) For purposes of this article:

(i) "Asset", with respect to an individual, means:

(A) All income and resources of the individual and of the individual's spouse, including any income or resources to which the individual or his spouse is entitled but does not receive because of action:

(I) By the individual or his spouse;

(II) By a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or his spouse; or

(III) By any person, including a court or administrative body, acting at the direction or upon the request of the individual or his spouse.

(B) An annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to long-term care services unless the annuity is an annuity as described in 42 U.S.C. 1396p(c)(1)(G)(i) or (ii).

(ii) "Income" means "income" as defined under 42 U.S.C. 1396p(h)(2);

(iii) "Institutionalized individual" means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is receiving home and community-based services;

(iv) "Long-term care services" means nursing facility services, a level of care in any institution equivalent to that of nursing facility services, and home and community-based services;

(v) "Resources" means "resources" as defined under 42 U.S.C. 1396p(e)(5);

(vi) "Department" means the department of health unless otherwise specified.

42-2-402. Transfers of assets affecting eligibility; exceptions; disclosures by applicants.

(a) If an institutionalized individual or the individual's spouse has disposed of, for less than fair market value, any asset or interest therein within sixty (60) months before or any time after the first date the individual has both applied for medical assistance and been institutionalized, the individual is ineligible for medical assistance for long-term care services for the period of time determined under subsection (b) of this section.

(b) For a transfer within the provisions of subsection (a) of this section, the number of months of ineligibility for long-term care services shall be the total, cumulative uncompensated value of all assets transferred within the sixty (60) month period, divided by the average monthly cost to a private patient for nursing facility services on the date of application. The period of ineligibility begins with the later of:

(i) The first day of the first month in which the assets were transferred and which does not occur in any other period of ineligibility;

(ii) The date on which the individual is eligible for medical assistance under the state plan and would otherwise be receiving institutional level care, but for the application of the penalty period, and which does not occur during any other period of ineligibility under this section.

(c) In the case of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance under this section for the individual, the department shall, using a reasonable methodology as specified by the secretary of health and human services, apportion the period of ineligibility for any portion of the period, among the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under chapter 4 of this title.

(d) An institutionalized individual is not rendered ineligible for long-term care services due to a transfer within the provisions of subsection (a) of this section if the asset transferred was a home and:

(i) Title to the home was transferred to the individual's:

(A) Spouse;

(B) Child who is under age twenty-one (21);

(C) Blind or disabled child as defined in 42 U.S.C. 1382c;

(D) Sibling who has equity interest in the home and who was residing in the home for a period of at least one (1) year immediately before the date the individual became an institutionalized individual; or

(E) Child who was residing in the home for a period of at least two (2) years immediately before the date the individual became an institutionalized individual, and who provided care to the individual which permitted the individual to reside at home rather than in an institution or facility.

(e) An institutionalized individual is not rendered ineligible for long-term care services due to a transfer within the provisions of subsection (a) of this section if the department determines:

(i) The individual intended to dispose of the asset at fair market value or for other valuable consideration;

(ii) The asset was transferred exclusively for a purpose other than to qualify for medical assistance;

(iii) That to the extent assets were transferred for less than fair market value, that the assets or their fair market equivalent have been returned to the individual; or

(iv) To grant a waiver of the excess resources created by the uncompensated transfer because denial of eligibility would cause undue hardship for the individual, based on criteria established by the secretary of health and human services.

(f) An institutionalized person who has made or whose spouse has made a transfer within the provisions of subsection (a) of this section is not ineligible for long-term care services if the asset was transferred:

(i) To the individual's spouse or to another individual for the sole benefit of the individual's spouse;

(ii) From the individual's spouse to another individual for the sole benefit of the individual's spouse;

(iii) To the individual's child who is blind or disabled, as defined by 42 U.S.C. 1382c, or to a trust established solely for the benefit of the child;

(iv) To a trust established solely for the benefit of an individual under sixty-five (65) years of age who is disabled as defined by 42 U.S.C. 1382c(a)(3).

(g) An applicant for long-term care services shall disclose any interest the applicant, or the applicant's spouse who is not residing in long-term care, has in an annuity or similar financial instrument, regardless of whether the annuity or instrument is irrevocable or is treated as an asset. For purposes of subsection (a) of this section, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless:

(i) The state is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant under this article; or

(ii) The state is named as the remainder beneficiary in the second position after the spouse or minor or disabled child and is named in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

42-2-403. Trust transfers affecting eligibility for medical assistance.

(a) For purposes of determining an individual's eligibility for or the amount of benefits under chapter 4 of this title, the rules specified in subsections (d) and (e) of this section shall apply to a trust established by the individual.

(b) For purposes of this section, a trust shall be considered to have been established if an asset of an individual, other than an asset transferred by will, was used to

form all or part of the corpus of the trust by any of the following:

(i) The individual;

(ii) The individual's spouse;

(iii) A person including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse;

(iv) A person including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(c) In the case of a trust the corpus of which includes assets of any other person, the provisions of this section shall apply to the portion of the trust attributable to the assets of the individual. This section shall apply without regard to:

(i) The purposes for which a trust is established;

(ii) Whether the trustees may exercise any discretion under the trust;

(iii) Any restrictions on when or whether distributions may be made from the trust; or

(iv) Any restrictions on the use of distributions from the trust.

(d) In the case of a revocable trust:

(i) The corpus of the trust shall be considered resources available to the individual;

(ii) Payments from the trust to or for the benefit of the individual shall be considered income of the individual; and

(iii) Any other payments from the trust shall be considered assets disposed of by the individual for purposes of W.S. 42-2-402.

(e) In the case of an irrevocable trust:

(i) If there are any circumstances under which payment from the trust could be made to or for the benefit of

the individual, the portion of the corpus or corpus income from which payments to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income to or for the benefit of the individual shall be considered income of the individual. Payments from that portion of the corpus or income for any other purpose shall be considered a transfer of assets by the individual subject to W.S. 42-2-402; and

(ii) Any portion of the trust or corpus income from which no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust or, if later, the date on which payment to the individual was foreclosed, to be assets disposed by the individual for purposes of W.S. 42-2-402. The value of the trust shall be determined for purposes of W.S. 42-2-402 by including the amount of any payments made from such portion of the trust after the date specified in this paragraph.

(f) Notwithstanding any other provision of this section, this section shall not apply to any of the following trusts:

(i) A trust containing the assets of an individual under age sixty-five (65) who is disabled as defined by 42 U.S.C. 1382c(a)(3) and which is established for the benefit of that individual by a parent, grandparent, legal guardian of the individual or a court if the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual under chapter 4 of this title;

(ii) A trust established for the benefit of an individual if:

(A) The trust is composed only of pension, social security and other income to the individual and accumulated income in the trust; and

(B) The state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual under chapter 4 of this title.

(iii) A trust containing the assets of an individual who is disabled as defined in 42 U.S.C. 1382c(a)(3), that meets the following conditions:

(A) The trust is established and managed by a nonprofit association;

(B) A separate account is maintained for each beneficiary of the trust but, for the purposes of investment and management of funds, the trust pools the accounts;

(C) Accounts in the trust are established solely for the benefit of individuals who are disabled as defined by 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; and

(D) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the state from the remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under chapter 4 of this title.

(g) The department shall establish procedures in accordance with standards specified by the secretary of health and human services under which the department waives the application of this section for an individual if the individual establishes that application would work an undue hardship on the individual as determined on the basis of criteria established by the secretary.

(h) For purposes of this section, "trust" includes any legal instrument or device that is similar to a trust but includes an annuity only to the extent and in the manner as the secretary of health and human resources specifies.

42-2-404. Determination of transfer of asset.

In the case of an asset held by an individual in common with another person in a joint tenancy, tenancy in common or similar arrangement, the asset, or the affected portion of the asset, shall be considered to be transferred by the individual when any action is taken, either by the individual or by any other person, that reduces or eliminates the individual's ownership or control of the asset.

42-2-405. Individuals with substantial home equity; disqualification.

(a) An applicant shall not be eligible for long-term care services under this article if the applicant's equity interest in the applicant's home exceeds five hundred thousand dollars (\$500,000.00).

(b) Beginning on July 1, 2011 and annually thereafter, the dollar amount in subsection (a) of this section shall be adjusted based on the consumer price index for urban consumers published by the United States department of labor, bureau of labor statistics, for the preceding calendar year.

(c) Subsection (a) of this section shall not apply to an individual whose spouse, or child under age twenty-one (21), is lawfully residing in the individual's home and is blind or disabled as defined in 42 U.S.C. 1382c.

(d) Nothing in this section shall be construed as preventing an applicant from using a reverse mortgage or home equity loan to reduce the applicant's total equity interest in the applicant's home.

ARTICLE 5 - ENERGY ASSISTANCE

42-2-501. Low income home energy assistance and weatherization program; funding.

(a) The department shall administer a low income home energy assistance program in accordance with federal P.L. 97-35, as amended. The department shall submit and keep current a state plan and shall administer the program in accordance with the state plan and this section.

(b) The program shall provide energy assistance to eligible households as provided in this section. Energy assistance shall include those uses of federal funds authorized under P.L. 97-35, as amended. To the extent permitted by federal law the state plan shall provide that of the authorized uses not less than twenty-five percent (25%) of the available funding for the program shall be used for weatherization assistance. Weatherization assistance shall include the following for residential dwellings only:

(i) Weatherization needs assessments and audits;

(ii) Caulking, insulation, storm window and similar improvements to reduce energy use;

(iii) Furnace and heating system modifications and repairs;

(iv) Furnace replacement;

(v) Repealed By Laws 2013, Ch. 183, § 1.

(vi) Repair or replacement of water heaters and heating systems for portions of a dwelling;

(vii) Other measures as determined by the department to be necessary to ensure a safe, well-weatherized dwelling.

(c) In addition to categorically eligible individuals authorized under P.L. 97-35, as amended, the state plan shall provide eligibility for those households with incomes which do not exceed the lesser of:

(i) An amount equal to two hundred fifteen percent (215%) of the federal poverty level for Wyoming; or

(ii) An amount equal to sixty percent (60%) of the state median household income.

(d) The department may modify the state plan as necessary:

(i) To meet federal requirements not to exclude households with lesser incomes than the amounts specified in subsection (c) of this section; and

(ii) To exclude households from receiving federal funds if the household income limitation provided in this section would violate federal restrictions.

(e) The maximum assistance provided to any household under the program in any state fiscal year shall not exceed the federal department of energy maximum annual unit average as calculated and authorized under P.L. 106-469, as amended.

(f) The department may adopt rules and regulations as necessary to implement this section.

CHAPTER 3 - CHILD SUPPORT AND REVENUE ENHANCEMENT ACCOUNT

42-3-101. Creation; deposits.

(a) The child support and revenue enhancement account is created.

(b) The following payments, collections and revenues shall be transmitted to the state treasurer for deposit to the credit of the child support and revenue enhancement account:

(i) Child support payments collected under the Child Support Enforcement Act;

(ii) Fees collected pursuant to W.S. 20-6-105(b); and

(iii) All funds collected under the overpayment and fraud recovery program of the department.

(c) For purposes of this chapter, "department" means the department of family services created by W.S. 9-2-2006.

42-3-102. Administration.

The department shall administer the funds in the child support and revenue enhancement account and report annually to the joint appropriations interim committee and joint judiciary interim committee. The account may be divided into subaccounts for purposes of administrative management.

42-3-103. Authorized expenditures.

(a) Funds in the child support and revenue enhancement account shall be expended only as authorized by this section.

(b) The department may at any time disburse funds in the account for:

(i) Payments to support obligees and disbursements required under the guidelines of the federal child support enforcement program;

(ii) Authorized transfers of the federal share of funds collected under the child support enforcement program and the division's overpayment and fraud recovery program;

(iii) Incentive payments as provided by W.S. 20-6-106(j);

(iv) Reimbursement to the department of health for costs under Title XIX of the Social Security Act or may retain

funds to pay for the costs of foster care or minimum medical program benefits; and

(v) Reimbursement to service providers for the costs of collection under the child support enforcement and overpayment recovery programs.

(c) Subject to legislative appropriation, the state's share of funds in the account shall be expended for:

(i) Administrative costs of the child support enforcement program;

(ii) Funding of benefits under the personal opportunities with employment responsibilities (POWER) program; and

(iii) Other administrative costs of the department.

(d) Notwithstanding any other provision of this section, if funds are recovered by the department under the overpayment and fraud recovery program within the same biennial period during which the funds were originally appropriated, the department may expend those funds for the purposes for which they were appropriated without further legislative appropriation.

CHAPTER 4 - MEDICAL ASSISTANCE AND SERVICES

ARTICLE 1 - IN GENERAL

42-4-101. Short title.

This chapter may be cited as the "Wyoming Medical Assistance and Services Act". The program and services provided pursuant to this chapter and Title XIX of the federal Social Security Act may be cited as "Medicaid" or the "Medicaid program".

42-4-102. Definitions.

(a) As used in this chapter:

(i) "Categorically eligible" means any individual in need of medical assistance authorized by the legislature and by Title XIX of the federal Social Security Act to be covered by a state plan for medical assistance and services;

(ii) "Medical assistance" means partial or full payment of the reasonable charges assessed by any authorized provider of the services and supplies enumerated under W.S. 42-4-103 and consistent with limitations and reimbursement methodologies established by the department, which are provided on behalf of a qualified recipient, excluding those services and supplies provided by any relative of the recipient, unless the relative is a family caregiver providing services through a corporation or a limited liability company, which corporation or limited liability company the relative may own, under a home and community based waiver program, or for cosmetic purposes only;

(iii) "Qualified" means any categorically eligible individual satisfying eligibility criteria imposed by this chapter, the state plan for medical assistance and services and by rule and regulation of the department;

(iv) "Relative" means any person as defined by department rule and regulation;

(v) "Resident" means any individual residing in this state, including any individual temporarily absent from this state;

(vi) "Institutionalized spouse" means as defined by the Medicare Catastrophic Coverage Act of 1988, P.L. 100-360;

(vii) "Department" means the state department of health;

(viii) "Direct patient care personnel" means only:

(A) Certified nursing assistants;

(B) Licensed practical nurses;

(C) Registered nurses.

(ix) "Skilled nursing home extraordinary care" means skilled nursing home services clearly exceeding standard skilled nursing home services and meeting the criteria established by the department pursuant to W.S. 42-4-104(d);

(x) "Intermediate care facility for people with intellectual disability" means "intermediate care facility for the mentally retarded" or "ICFMR" or "ICFs/MR" as those terms

are used in federal law and in other laws, rules and regulations;

(xi) "Family caregiver" means a relative of a waiver recipient with a developmental disability or acquired brain injury, who provides waiver services through a corporation or a limited liability company, which corporation or limited liability company the relative may own, to the person with a developmental disability or acquired brain injury and who meets the requirements for a qualified family caregiver as established by rules promulgated by the department. Family caregivers shall be certified by the department in the same manner as nonfamily caregivers. For purposes of providing for reimbursement of services to a family caregiver, the department shall amend the state plan and apply for a waiver from the centers for Medicaid and Medicare services, as necessary;

(xii) "Intentional" means that a person, with respect to information, intended to act in violation of the law;

(xiii) "Knowing" or "knowingly" includes intentional or intentionally and means that a person, with respect to information, acts:

(A) With actual knowledge of the information;

(B) In deliberate ignorance of the truth or falsity of the information; or

(C) In reckless disregard of the truth or falsity of the information.

42-4-103. Authorized services and supplies.

(a) Services and supplies authorized for medical assistance under this chapter include:

(i) Inpatient hospital services;

(ii) Outpatient hospital services;

(iii) Laboratory and x-ray services;

(iv) Skilled nursing home services;

(v) The professional services of a licensed and certified physician, osteopathic physician or chiropractic doctor;

(vi) Home health services;

(vii) Family planning services;

(viii) Services provided by an authorized rural health care clinic;

(ix) Midwife services provided by a:

(A) Certified nurse midwife licensed by the board of nursing;

(B) Midwife licensed by the board of midwifery.

(x) Early and periodic screening, diagnosis and treatment for individuals who have not attained the age of twenty-one (21) years in accordance with Title XIX of the federal Social Security Act;

(xi) Premiums, deductibles and coinsurance under federal Medicare Part A, hospital insurance, and Part B, supplemental medical insurance;

(xii) The professional services of a licensed optometrist;

(xiii) Prescription drugs and oxygen;

(xiv) Prosthetic devices which are necessary to replace a missing portion of the body or assist in correcting a dysfunctional portion of the body including training required to implement the use of the device but excluding dental prostheses;

(xv) Licensed rehabilitation center services and if specifically prescribed by a licensed physician, outpatient services of a privately operated licensed occupational, speech, audiology or physical therapy center and the professional services of a licensed occupational therapist, licensed speech pathologist, licensed audiologist or a licensed physical therapist;

(xvi) Services provided by an institution for mental illnesses;

(xvii) Services provided under a federal home and community based waiver;

(xviii) The professional services of a licensed dentist which may be legally and alternatively performed by a licensed physician or osteopathic physician and except as provided under paragraph (a)(x) of this section, which are not primarily provided for the care, treatment or replacement of teeth or structures directly supporting teeth;

(xix) Services provided by a freestanding ambulatory surgical center;

(xx) Services provided by a certified mental health center or community substance abuse treatment center; mental health services provided to qualified recipients by a licensed physician or under the direction of a physician if an individual treatment plan is established in writing, approved and periodically reviewed by a licensed physician; services provided by a licensed mental health professional. Authorized services shall include services provided by a person holding a provisional license as a mental health professional if the services were provided under the supervision of a licensed mental health professional. The department of health shall by rule and regulation or within the state plan for medical assistance and services, define those services qualifying as mental health services under this paragraph and, pursuant to W.S. 9-2-102, establish standards for certification under this paragraph. As used in this paragraph "licensed mental health professional" means a licensed professional counselor, a licensed marriage and family therapist, a licensed addictions therapist or a licensed clinical social worker;

(xxi) Services provided by intermediate care facilities;

(xxii) Services provided by an intermediate care facility as defined under 42 U.S.C. § 1396d(d);

(xxiii) Services provided by freestanding end stage renal dialysis clinics or centers;

(xxiv) Services provided by advanced practitioners of nursing;

(xxv) Hospice care as defined in W.S. 35-2-901(a)(xii) and authorized under 42 U.S.C. § 1396a(a)(10)(A)(ii)(VII) including hospice care in a hospice facility for an eligible individual and room and board for individuals receiving the care in a hospice facility. Reimbursement rates for hospice care shall be set annually to match Medicare hospice reimbursement rates. The room and board reimbursement rate for hospice facilities shall not exceed one hundred percent (100%) of the statewide average of the Medicaid nursing home room and board rate when an eligible individual is receiving hospice. For the purposes of this paragraph, "eligible individual" means a person who is eligible for hospice care as defined in the state Medicaid plan in effect on July 1, 2012;

(xxvi) Tuberculosis ambulatory care authorized under 42 U.S.C. § 1396a(a)(10)(A)(ii)(XII);

(xxvii) Targeted case management services, which shall be services which will assist targeted individuals eligible under the state plan in gaining access to needed medical, social, educational and other services;

(xxviii) Skilled nursing home extraordinary care in accordance with W.S. 42-4-104(d);

(xxix) Bone marrow, kidney and liver transplant services;

(xxx) Programs and services provided under the school health program;

(xxxii) Services of a licensed dietitian;

(xxxiii) Air ambulance transport services, consistent with W.S. 42-4-123;

(xxxiv) Clubhouse rehabilitation services in accordance with W.S. 42-4-124;

(xxxv) The professional services of a school psychologist;

(xxxvi) The professional services of a school social worker;

(xxxvii) School based services delivered pursuant to an individualized education program, including services:

(A) Provided by an otherwise enrolled Medicaid provider type;

(B) Provided by a licensed professional in a school setting; or

(C) Otherwise covered under this chapter to support delivery of special education programs and services.

(xxxvii) The professional services of a licensed pharmacist;

(xxxviii) Podiatry services provided by a podiatrist licensed by the board of registration in podiatry, if referred to a podiatrist by a physician, physician assistant or an advanced practice registered nurse;

(xxxix) Services provided by birthing centers as defined by W.S. 35-2-901(a)(iii).

(b) In addition to other payments authorized under this chapter, the department may provide payments to skilled nursing homes which are providing services covered under this chapter if:

(i) The nursing home demonstrates that one hundred percent (100%) of the additional amount received will be expended upon direct patient care personnel salaries and benefits; and

(ii) The nursing home agrees to provide sufficient data to the department substantiating compliance with paragraph (i) of this subsection.

(c) For purposes of implementing Medicaid reform pursuant to 2013 Wyoming Session Laws, Chapter 117, the department may apply for any applicable waivers or permissions to allow exceptions to federal conflict free case management definitions for frontier and rural areas, which to the extent consistent with federal law, shall implement a system using a neutral third party to ensure no conflicts exist. Consistent with federal law, the department may phase in the independent case management system. In negotiating a waiver pursuant to this subsection, the department shall, to the extent practicable and approved by the center for Medicare and Medicaid services:

(i) Allow an individual or agency to provide case management and direct services to discrete clients if the services are provided under conflict free circumstances;

(ii) When implementing updated case manager educational standards, provide for a three (3) year transition period and allow credit for prior case manager experience.

42-4-104. Powers and duties of department of health; state Medicaid agent appointed by governor.

(a) The department of health shall:

(i) Administer this chapter;

(ii) Develop a state plan for medical assistance and services provided to qualified recipients under this chapter and otherwise providing for the effective administration of this chapter;

(iii) Maintain records on the administration of this chapter, report to the federal government as required by federal law and regulation and within limitations imposed under W.S. 42-4-112, may provide for the availability of information on the administration of this chapter to interested persons;

(iv) Adopt, amend and rescind rules and regulations on the administration of this chapter following notice and public hearing in accordance with the Wyoming Administrative Procedure Act.

(b) In carrying out subsection (a) of this section, the department may:

(i) Advise, consult and cooperate with any state agency or political subdivision, any other state, the federal government, private industry and other interested persons;

(ii) Negotiate and enter into contract with other public and private agencies and persons as necessary to administer this chapter;

(iii) Directly or by contract and through one (1) or more fiscal intermediaries, provide payments to providers of services and supplies for medical assistance authorized by this chapter in the manner and amount provided by this chapter;

(iv) Receive funds from any source for purposes of carrying out this chapter;

(v) Establish reasonable limits on services and supplies authorized under W.S. 42-4-103;

(vi) Conduct pilot projects pursuant to W.S. 42-4-107(c);

(vii) Provide for part or all of the services and supplies authorized under W.S. 42-4-103 for some or all categorically eligible individuals through health care insurance or through contracts with networks of health care providers;

(viii) Purchase stop gap insurance;

(ix) Enter into intergovernmental transfer arrangements with qualifying facilities and providers, including but not limited to hospitals, nursing homes, hospital owned and operated professional service providers and ground ambulance service providers, in which all federal funding received as a result of the intergovernmental transfer arrangements shall be distributed to participating facilities and providers in accordance with the terms of an approved state plan amendment or other agreement with the centers for Medicare and Medicaid services. Notwithstanding, if consistent with the state plan amendment or agreement, the department may use funds derived from such intergovernmental transfers to pay administrative expenses incurred by the department or its agent in performing the activities authorized under this subsection, provided that these expenses shall not exceed a total of three percent (3%) of the aggregate intergovernmental transfer funds collected in the fiscal year;

(x) Provide for the withholding of medical assistance payments from nursing care facilities in accordance with W.S. 42-8-107(b)(i).

(c) Subject to limitations imposed under this subsection, the department shall, at least once every five (5) years but not more than once in any three (3) year period, establish a new base period to be used in calculating all skilled nursing homes' medical assistance per diem base rate reimbursable under this chapter, using the most recent cost report information provided to the department. For purposes of medical assistance reimbursable under this chapter, the department shall reimburse

each eligible provider of skilled nursing home services the greater of the following amounts:

(i) Medical assistance computed on the per diem base rate under the new base period established pursuant to this subsection; or

(ii) For the state fiscal year beginning July 1, 2003 and ending June 30, 2004, medical assistance computed on the per diem base rate existing prior to the establishment of the new base period under this subsection.

(d) The department shall establish by rule the conditions and requirements for skilled nursing home extraordinary care. The requirements shall include, but are not limited to the following:

(i) The care shall be previously authorized by the department for each individual and subject to continual audit by the department;

(ii) The cost for the care shall clearly exceed the standard skilled nursing home per diem rate;

(iii) The cost shall be excluded from the nursing home's cost report to the department; and

(iv) No extraordinary care payment shall be made for equipment owned by the nursing home in providing the care.

(e) The chief administrator of the Medicaid program created pursuant to this chapter shall be the state Medicaid agent within the department of health, who shall be appointed by the governor, shall serve at the pleasure of the governor and may be removed by the governor as provided by W.S. 9-1-202. The state Medicaid agent shall oversee and coordinate all programs which provide Medicaid services or determine Medicaid eligibility pursuant to W.S. 42-4-106 and chapter 2 of this title.

42-4-105. Repealed by Laws 1991, ch. 221, § 3.

42-4-106. Application for assistance; determination of eligibility; assignment of benefits; resources and income allowances defined for institutionalized spouse.

(a) Any Wyoming resident may apply for medical assistance under this chapter by filing an application by telephone, by mail, in person at the eligibility customer service center in Cheyenne, on the eligibility internet site or at a department of family services field office located in the county in which the individual resides. A determination of eligibility for medical assistance shall be based upon the application. Medical assistance shall be provided on behalf of a qualified applicant with reasonable promptness.

(b) Upon signing an application for medical assistance under this chapter, an applicant assigns to the department any right to medical support or payment for medical expenses from any other person on his behalf or on behalf of any relative for whom application is made. The assignment is effective upon a determination of eligibility. Application for medical assistance shall contain an explanation of the assignment provided under this subsection.

(c) In determining the eligibility of an institutionalized spouse for medical assistance under this chapter, the resources of the noninstitutionalized spouse shall not be considered available to the institutionalized spouse to the extent the amount of his resources does not exceed the maximum authorized by the Medicare Catastrophic Coverage Act of 1988, P.L. 100-360. For purposes of determining the amount of an institutionalized spouse's monthly income to be applied towards payment of institutional care costs, the maximum amount of allowance authorized by the Medicare Catastrophic Coverage Act of 1988, P.L. 100-360 shall be deducted from his monthly income.

(d) In any assistance program under this chapter for which income is the criterion or one (1) of the criteria for assistance payments, compensation received for a veteran's service connected disability shall not be counted in determining income if that compensation on an annual basis is not more than the poverty level for the applicant as determined by the federal office of management and budget.

(e) *The following requirements shall be met before an applicant is eligible for medical assistance under this chapter:*
[NOTE: This subsection will be effective 7/1/2027.]

(i) *An applicant shall be a citizen or national of the United States and shall provide a valid social security number and proof of identity. An applicant considered to be lawfully present in the United States shall be eligible for*

medical assistance under this chapter. The requirement in this paragraph shall not apply when determining if the department of health will cover children in the custody of the department of family services;

(ii) An applicant shall be a Wyoming resident or meet the criteria specified in the Wyoming Medicaid state plan. An applicant who intends to return to the applicant's home in another state or country shall not be considered a Wyoming resident;

(iii) An applicant shall fulfill not less than one (1) of the following criteria:

(A) Be determined disabled according to social security guidelines by the social security administration or the department;

(B) Be entitled to receive supplemental security income or be eligible for supplemental security income-related programs;

(C) Be entitled to receive hospice services in accordance with a voluntary election and a health care provider statement of a terminal condition where:

(I) The applicant has received hospice services or resided in a medical institution for not less than thirty (30) consecutive days; or

(II) The applicant is not a supplemental security income recipient and dies before completion of the time requirement specified in subdivision (I) of this subparagraph.

(D) Be qualified for services, pursuant to rules of the department, under a Medicaid waiver or other expansion that the legislature has authorized;

(E) Be infected with tuberculosis and, if the person is not a Wyoming resident or United States citizen, is present in Wyoming and, if not treated, is a threat to infect Wyoming residents with tuberculosis;

(F) Be otherwise qualified for medical assistance pursuant to federal Medicaid regulations or be eligible under a mandatory requirement of the federal government for participation in Medicaid, provided that no expansion

eligibility for Medicaid beyond the eligibility as of January 1, 2026 shall occur without prior authorization by the legislature, except that the governor may authorize a temporary expansion in eligibility needed to combat a public health emergency, provided that the temporary expansion shall end not more than thirty (30) days after the adjournment of the next legislative session;

(G) Be a child in the custody of the department of family services in foster care, basic foster care, noncitizen foster care, subsidized adoption or in residence at the Wyoming boys' school or the Wyoming girls' school;

(H) Be enrolled in the 1115 family planning waiver. The department of health is authorized to continue operating the 1115 waiver until its planned expiration in December 31, 2027 and is not authorized to renew the waiver beyond this expiration date;

(J) Be enrolled in the employed individuals with disabilities program under section 1902(a)(10)(A)(ii)(XV) of the federal Social Security Act;

(K) Be enrolled in the breast and cervical cancer treatment program under section 1902(a)(10)(A)(ii)(XVIII) of the federal Social Security Act.

(iv) An applicant shall fulfill any other criteria required pursuant to rules of the department or federal Medicaid regulations.

42-4-107. Uniform application throughout state; discrimination prohibited; pilot projects authorized.

(a) This chapter and the state plan for medical assistance and services developed under W.S. 42-4-104(a)(ii) shall be uniformly applied within all political subdivisions of the state.

(b) The provision of medical assistance to any applicant or qualified recipient shall not be denied or delayed and the administration of this chapter shall not otherwise discriminate against any applicant or recipient on the basis of race, creed, color, national origin, sex or mental or physical handicap.

(c) Notwithstanding any other provision of this act, the department, in providing services and supplies authorized by

this act, may conduct pilot projects pertaining to some or all categorically eligible individuals.

42-4-108. Administrative hearings.

In accordance with the Wyoming Administrative Procedure Act, the department shall provide opportunity for a hearing to any individual denied medical assistance under this chapter or otherwise aggrieved by the administration of this chapter.

42-4-109. Renumbered and Repealed.

- (a) Renumbered as 42-4-207(a) by Laws 1994, ch. 73, § 2.
- (b) Renumbered as 42-4-207(b) by Laws 1994, ch. 73, § 2.
- (c) Repealed by Laws 1994, ch. 73, § 3.
- (d) Renumbered as 42-4-207(f) by Laws 1994, ch. 73, § 2.

42-4-110. Charges for inpatient hospital services.

A cost deduction, cost sharing or other similar charge shall not be imposed upon any recipient of medical assistance for inpatient hospital services provided on his behalf pursuant to this chapter.

42-4-111. Providing or obtaining assistance by misrepresentation; penalties.

- (a) Repealed by Laws 2019, ch. 96, § 3.
- (b) Repealed by Laws 2019, ch. 96, § 3.
- (c) No person shall knowingly make a false statement or misrepresentation or knowingly fail to disclose a material fact in obtaining medical assistance under this chapter. A person violating this subsection is guilty of a misdemeanor punishable by imprisonment for not more than six (6) months, a fine of not more than seven hundred fifty dollars (\$750.00), or both.
- (d) Repealed by Laws 2019, ch. 96, § 3.
- (e) Repealed by Laws 2019, ch. 96, § 3.

42-4-112. Confidentiality of records; penalty for disclosure; authorized disclosure.

(a) Any application, information and record obtained, compiled and maintained for an applicant or qualified recipient of medical assistance under this chapter is confidential and shall not be disclosed or used for any purpose other than the administration of this chapter.

(b) A violation of subsection (a) of this section is a misdemeanor.

(c) Notwithstanding subsection (a) of this section and any other provision of law to the contrary, and for purposes of ensuring any medical assistance under this act does not duplicate any benefit payment made by another state agency, insurer, group health plan, third party administrator, health maintenance organization or similar entity, the department may upon request of the state agency, insurer or similar entity, disclose information limited to a recipient's name, social security number, amount of payment, charge for services, date of services and services rendered relating to medical assistance payments made under this act. A state agency, insurer, group health plan, health maintenance organization or similar entity shall, upon request of the department, disclose the same limited information to the department. Information received under this subsection shall be used only for the purpose authorized by this subsection and shall otherwise be confidential and the state agency, insurer, group health plan, health maintenance organization or other recipient entity shall be subject to the confidentiality restrictions imposed by law upon information received to the extent required of the department. Any violation of this subsection is a misdemeanor punishable by imprisonment for not more than six (6) months, a fine of not more than seven hundred fifty dollars (\$750.00), or both.

(d) Prior to receipt of any payment under this act, the department shall require an applicant for or recipient of assistance under this act to sign a waiver authorizing the release of information limited to assistance payment information to state agencies, insurers, group health plans, third party administrators, health maintenance organizations or similar entities for purposes specified by subsection (c) of this section.

42-4-113. Eligibility criteria; irrevocable burial trusts.

(a) The department shall not consider as assets available to an applicant seeking medical assistance the corpus of a Medicaid qualifying trust:

(i) That is irrevocable;

(ii) In which the trustee and trustor retain no discretion with respect to distributions to the applicant;

(iii) In which the income from the trust shall be transferred to the applicant at least annually;

(iv) In which the trust corpus shall not exceed five thousand dollars (\$5,000.00); and

(v) In which the trust corpus is specifically and irrevocably designated, assigned, or pledged for payment of the applicant's burial expenses.

(b) If any of the trust corpus remains after payment of burial expenses, that remainder shall be transferred to the department to be used in the medical assistance program.

42-4-114. Cooperative agreements authorized.

The department may enter into a cooperative agreement and may contract with private attorneys to provide legal services and legal representation necessary to assist the department in enforcing its right to reimbursement created under article 2 of this chapter. The department and its contract attorneys shall have an unconditional right to intervene in any action by or on behalf of a recipient or former recipient against any third party who may be legally liable to reimburse any medical assistance provided under the Wyoming Medicaid program. If no action has been brought, the department and its contract attorneys may initiate and prosecute an independent action on behalf of the department against any third party that may be liable to the person to whom the care was furnished. If the department elects not to contract with private attorneys to provide legal services and representation under this section, the attorney general, or an appropriate county attorney, shall provide the legal services and representation.

42-4-115. Work incentives improvement option; purchase of services; eligibility criteria; definition.

(a) The department may amend the state plan for medical assistance and services developed under W.S. 42-4-104(a)(ii) to allow individuals with countable income not to exceed three hundred percent (300%) of the supplemental security income level to receive services authorized under W.S. 42-4-103(a), provided that:

(i) Repealed by Laws 2002, Ch. 31, § 2.

(ii) Repealed By Laws 2002, Ch. 31, § 2.

(iii) The individual is eligible to buy into the Wyoming Medical Assistance and Services Act under the federal Ticket to Work and Work Incentive Improvement Act of 1999 and subsequent similar federal enactments and the federal government is not restricted from paying its proportionate share of the individual's eligible medical expenses;

(iv) Provided that the individual's earnings do not exceed the level specified in section 201(a)(3) of the Federal Ticket to Work and Work Incentive Improvement Act of 1999; and

(v) The individual pays to the department a premium of seven and one-half percent (7.5%) of his total gross earnings from work and seven and one-half percent (7.5%) of his unearned income in excess of six hundred dollars (\$600.00) per year, provided that:

(A) The total paid in premiums under this section does not exceed the yearly premium as calculated pursuant to W.S. 42-4-116; and

(B) The individual is not liable for more than the full premium calculated pursuant to W.S. 42-4-116.

(b) If the federal government does not allow a state plan amendment containing the expense limitations provided in paragraphs (a)(i) and (ii) of this section or provisions with similar fiscal effects, the state plan amendment authorized by this section shall not be implemented without specific legislative authorization.

(c) With respect to the premium received pursuant to subsection (a) of this section, the department shall deduct and forward to the federal government any amount owed under federal regulations. Any overpaid premium shall be refunded to the individual and the balance shall be deposited in the general

fund. The sum of all amounts deposited under this section shall be reported in the biennial budget submissions to the joint appropriations interim committee as premium earned to offset the expenses of the program.

(d) Repealed by Laws 2015, ch. 54, § 2.

(e) Repealed by Laws 2002, Ch. 31, § 2.

(f) Repealed By Laws 2002, Ch. 31, § 2.

42-4-116. Premium calculation.

(a) The calculation of premium for services under W.S. 42-4-115 shall be as follows:

(i) Determine the total expenses of the Medicaid program for the most recent state fiscal year and the total number of clients in the Medicaid program served in that period;

(ii) Deduct from the totals in paragraph (i) of this subsection the clients over the age of sixty-five (65) years and the expenses associated with those clients;

(iii) Divide the resulting expenses calculated pursuant to paragraph (ii) of this subsection by the clients remaining after the deduction pursuant to paragraph (ii) of this subsection. The result is the basic annual premium;

(iv) Add to the basic premium a risk factor of fifty percent (50%) of the basic premium to recover additional costs incurred by the population eligible to be served pursuant to W.S. 42-4-115; and

(v) The premium shall be the sum of the basic annual premium calculated pursuant to paragraph (iii) of this subsection and the risk factor calculated pursuant to paragraph (iv) of this subsection.

42-4-117. End stage renal dialysis program; rulemaking; funding.

(a) Effective July 1, 2001, the department shall expand coverage for services authorized under W.S. 42-4-103(a) (xxiii) for qualified individuals in need of end stage renal dialysis to the extent funding is available.

(b) The department shall by rule and regulation establish reasonable limits on services and supplies authorized under this section, including establishing eligibility criteria for receipt of services. In establishing eligibility criteria, the department shall consider financial ability of the individual or his family to contribute to the services, severity of the illness, the critical need for the services and the ability of the program to meet the needs of the individual.

42-4-118. Prescription drug assistance program created; eligibility criteria; benefits provided; coverage of medications.

(a) There is created a prescription drug assistance program to assist residents of the state. The program shall be a state funded program to provide prescription drug assistance, in addition to the services provided under the Wyoming Medical Assistance and Services Act. Effective July 1, 2002, the prescription drug assistance program shall replace the minimum medical program. Eligibility for assistance under the program created by this section shall not constitute an entitlement and services shall be provided under this section only to the extent funds are available.

(b) Residents of the state may apply for the prescription drug assistance program in the manner provided in W.S. 42-4-106. Upon a determination of eligibility, the applicant remains eligible for assistance under the prescription drug assistance program as provided in this section. If a recipient ceases to be a resident of the state, his eligibility under the program shall terminate. The department shall by rule and regulation establish income eligibility guidelines no later than July 1 of each year based on the federal poverty levels in effect on January 1 of that calendar year. Persons with family income of one hundred percent (100%) of the federal poverty level or less shall be eligible under this section. The rules shall take into consideration family size up to four (4) individuals. Eligibility for families consisting of more than four (4) individuals shall be determined on the basis of the income of a family of four (4) individuals. Persons eligible for prescription drug assistance under other state or federal programs, except the state high risk health insurance pool, shall be ineligible for assistance under the prescription drug assistance program.

(c) Except as provided by this subsection, an eligibility determination made under subsection (b) of this section shall be

valid for one (1) year. A recipient whose monthly income changes by more than one-third (1/3), shall report the change in income to the department. The recipient is entitled to a redetermination if his income has declined and may, at the option of the department, be subject to a redetermination if his income has increased.

(d) A recipient shall be required to pay a copayment per prescription of ten dollars (\$10.00) for generic drugs and twenty-five dollars (\$25.00) for brand name drugs.

(e) The department shall project costs of the program created by this section at least quarterly and compare those projected costs against the funds appropriated for the program. If the funds available to the program are insufficient to meet the projected costs of the program, the department shall take action to prevent the program from incurring costs beyond available funds, including taking any of the following actions:

(i) Imposing a moratorium on new enrollments in the program;

(ii) Reducing the gross family income eligibility level specified in subsection (b) of this section;

(iii) Imposing higher prescription drug copayments not to exceed twenty-five dollars (\$25.00) per prescription;

(iv) Eliminating specified drugs from eligibility under the program;

(v) Carrying claims for payment into the next biennium if the amount of claims are less than one twenty-fourth (1/24) of the appropriation that has been enacted for the next biennium.

42-4-119. Pharmacy plus program; eligibility criteria; rulemaking; termination of program.

(a) The department may apply for a demonstration waiver under section 1115 of the federal Social Security Act to allow individuals with income or assets in excess of limits generally established in the state plan to receive services under a pharmacy plus program provided that:

(i) The individual is a beneficiary under the federal Medicare program who has not been determined to be eligible for full Medicaid benefits under the state plan;

(ii) The total family income of the individual does not exceed one hundred seventy-five percent (175%) of the federal poverty level in effect on April 1 of that calendar year;

(iii) The total family net assets of the individual do not exceed three hundred fifty thousand dollars (\$350,000.00); and

(iv) An individual determined eligible to receive services under this section shall not be eligible for other services under W.S. 42-4-103, unless the individual otherwise qualifies for the services. Eligibility for assistance under the program created by this section shall not constitute an entitlement and services shall be provided under this section only to the extent funds are available.

(b) The department is directed to negotiate the terms and conditions of the waiver with the United States secretary of health and human services as necessary to implement this section.

(c) Upon approval of the final terms and conditions by the United States secretary of health and human services and the legislature of the waiver applied for under this section, the department shall implement the pharmacy plus program to assist eligible individuals with payment and management of prescription drug costs. In implementing the pharmacy plus program, the department may use private sector benefit management approaches, including pharmacy benefit managers, preferred drug lists, prior authorization, pharmacist consultation, provider education, disease state management and variable enrollee cost sharing in the form of annual or monthly premium assessments, per prescription copayment requirements, coinsurance, deductibles and coverage limits. The department shall establish through rules and regulations variable enrollee cost sharing provisions under this subsection on a graduated basis, taking into consideration the differing income levels of enrollees and the funding available to the program.

(d) If the federal Medicare program is amended to provide pharmaceutical benefits for recipients under that program, the pharmacy plus program authorized under this section shall

terminate upon implementation of the federal Medicare pharmaceutical benefits program.

(e) The department shall project costs of the program created by this section at least quarterly and compare those projected costs against the funds appropriated for the program. If the funds available to the program are insufficient to meet the projected costs of the program, the department shall take action to prevent the program from incurring costs beyond available funds, including taking any of the actions specified in W.S. 42-4-118(e).

42-4-120. Contracts for waiver services; authority of department; emergency case services; cost based payments; training and certification of specialists.

(a) The department is authorized to enter into contracts with providers of services under a federal home and community based waiver and to enforce the provisions of this section.

(b) The department shall adopt and enforce reasonable rules and regulations for the certification of home and community based waiver services, and shall include minimum certification standards for each category of service provider.

(c) Before entering into a contract with a provider of services under this section, the department shall ascertain that the provider is in compliance with applicable regulations regarding health care providers adopted pursuant to W.S. 35-2-908, with all applicable professional licensing statutes and regulations and with regulations adopted pursuant to subsection (b) of this section.

(d) In addition to other remedies, in the event of a chronic failure to provide services or services that fail to meet the applicable standard of care for the profession involved or a continuing condition creating serious detriment to the health, safety or welfare of recipients of home and community based waiver services, the department may impose a civil penalty upon the provider. For each day of continuing violation, the civil penalty shall not exceed one thousand dollars (\$1,000.00) or one percent (1%) of the amount paid to the provider during the previous twelve (12) months, whichever is greater, and any administrative penalty assessed under this section shall be paid over to the state treasurer who shall remit the monies to the county treasurer to the credit of the public school fund of the county in which the violation occurred, except as otherwise

provided by federal law for Medicaid certified nursing facilities.

(e) The department shall have the same authority to place conditions upon a provider, to impose a monitor or to revoke a certification issued under this section in the manner described in W.S. 35-2-905.

(f) The department, not later than April 1, 2008, shall promulgate rules under which an emergency case shall be determined to exist with respect to eligibility for federal home and community based waiver services for persons with developmental disabilities or adult brain injury under this act.

(g) The department shall establish by rule and regulation a cost based reimbursement system to pay providers of services and supplies under home and community based waiver programs for persons with developmental disabilities or acquired brain injury. The payment system shall:

(i) Use information provided to the department, including but not limited to:

- (A) Provider cost data;
- (B) Provider claims data;
- (C) Participant needs assessment data;
- (D) Other relevant regional and national data.

(ii) Establish a new base period to be used in calculating reimbursement rates to providers for fiscal year 2012 and at least once every four (4) years thereafter but not more than once in any two (2) year period. When a new base period is established, the department shall submit a biennial or supplemental budget request to adjust provider reimbursement rates based on the most current base period;

(iii) Be developed following consultation with Wyoming developmental disability and acquired brain injury waiver program service providers, developmental disability waiver program clients and their families and an expert in cost based waiver program payment systems, which the department is authorized to retain by contract following competitive bidding;

(iv) Be implemented for services and supplies provided under individual budget amounts established on and after July 1, 2008;

(v) Be contingent upon approval by the center for Medicare and Medicaid services of the United States department of health and human services;

(vi) Require service and supply providers to provide actual cost of service and supply data to the department and to submit to reasonable audits of the submitted data, if requested by the department.

(h) The department shall apply to the center for Medicare and Medicaid services of the United States department of health and human services for authorization to reimburse at an enhanced rate direct care providers who have training and certification as behavioral specialists in the care of persons dually diagnosed with a developmental disability and a mental illness.

(j) The department, through the developmental disabilities division and the mental health and substance abuse services division, shall collaborate with the University of Wyoming institute for disabilities and the community college commission in developing a training program for behavioral specialists in the care of persons dually diagnosed with a developmental disability and a mental illness. The program shall provide for timely testing and certification and shall include a required curriculum and standards for certification and evaluation of dual diagnosis behavioral specialists where certificants will qualify for reimbursement under the requirements of subsection (h) of this section.

(k) Department budget requests for the cost based reimbursement system established pursuant to subsection (g) of this section shall be calculated to reflect all service units required in plans of care for recipients as of the preceding June 30.

(m) The department shall ensure that state agencies working with service providers receiving funds pursuant to this section shall have established employment first policies, including competitive employment in an integrated setting, consistent with the requirements of W.S. 9-2-3207.

(n) For purposes of this section, "military service member" means any person serving in the uniformed services as

defined in W.S. 8-1-102(a)(xxii). Military service members shall have the following benefits if they meet the qualifications listed:

(i) Active duty military service members who have been assigned to serve in Wyoming may submit an application for waiver services under this paragraph upon receiving military orders to serve in Wyoming, provided that no qualifying dependent shall receive services until the dependent is residing in Wyoming;

(ii) Active duty military service members retiring or separating from active duty military service may submit an application for waiver services under this paragraph upon receiving retirement or separation orders, provided that:

(A) The military member certifies on a form provided by the department that he intends to reside in Wyoming within eighteen (18) months after retiring or separating from military service;

(B) The military service member claimed Wyoming as his primary state of residency for not less than two (2) years prior to his military service as proved by documentation required by the department;

(C) The military service member claimed Wyoming residency on his leave and earnings statements while serving in the military; and

(D) No covered services shall be received pursuant to this paragraph unless and until the qualifying dependent and the military service member are residing in Wyoming within eighteen (18) months after the military service member retires or separates from active military service.

(iii) Military service members who qualified for and received or were previously placed on the waiting list to receive dependent waiver services under the home and community based Medicaid waivers authorized by this section, and who left the state for military reasons, shall upon their return to the state for continued military service or upon military separation or retirement be placed in a status identical to where they would be if they had not left the state provided that:

(A) The military service member claimed Wyoming residency on his leave and earnings statements while serving in the military; and

(B) For retiring or separating military service members, in no case shall covered services be received pursuant to this paragraph unless and until the military service member and the qualifying dependent are residing in Wyoming within eighteen (18) months after the military service member retires or separates from active military service.

(o) Applicants who are qualifying military service members under subsection (n) of this section may also be considered for funding made available to any other applicant under this section and shall receive services from whatever source of funding for which they first qualify. In consultation with the Wyoming military department, the department of health shall promulgate rules and regulations regarding applications and qualifications for waiver services authorized by subsection (n) of this section.

42-4-121. Program of all-inclusive care for the elderly.

(a) The department, as an optional services program of the Medicaid program, may develop and implement a program of all-inclusive care for the elderly (PACE) in accordance with section 4802 of the Balanced Budget Act of 1997, P.L. 105-33, as amended, and 42 C.F.R. part 460.

(b) The department may contract with approved PACE organizations to provide, in the manner and to the extent authorized by federal law, comprehensive, community based acute and long term care services for older Medicaid eligible participants who are at least fifty-five (55) years old, living in a PACE service area, certified by the department as eligible for long term care facility placement and who elect to participate in the PACE program. Services provided through a PACE organization shall include all necessary medical and related care required by the PACE participant, including but not limited to physician and other health care provider visits, regular check ups, prescription drugs, rehabilitation services, home and personal care services, medically necessary transportation, hospitalization and skilled nursing facility services.

(c) The objective of the PACE program is to provide prepaid, capitated, quality comprehensive health care services that are designed to:

(i) Enhance the quality of life and autonomy for frail, older adults;

(ii) Maximize dignity of, and respect for, older adults;

(iii) Enable frail, older adults to live in the community as long as medically and socially feasible;

(iv) Preserve and support the older adult's family unit.

(d) The department shall adopt rules as necessary to implement this section. In adopting rules, the department shall:

(i) Provide application procedures for organizations seeking to become a PACE program provider;

(ii) Establish the capitation rate for Medicaid participants electing to participate in the PACE program instead of receiving Medicaid services on a fee for service basis. The capitation rate shall be no less than ninety percent (90%) of the fee for service equivalent cost, including the department's cost of administration, that the department estimates would be payable for all services covered under the PACE organization contract if all of those services were to be provided on a fee for service basis;

(iii) Provide application procedures, including acknowledgment of informed consent, for Medicaid participants electing to participate in the PACE program in lieu of receiving fee for service Medicaid benefits.

(e) PACE provider organizations shall be public or private organizations providing or having the capacity to provide, as determined by the department, comprehensive health care services on a risk based capitated basis to PACE patients.

(f) To demonstrate capacity as required by subsection (e) of this section, the department shall consider evidence such as an organization's insurance, reinsurance, cash reserves, letters

of credit, guarantees of companies affiliated with the organization or a combination of those arrangements.

(g) PACE organizations shall assume responsibility for all costs generated by PACE program participants, and shall create and maintain a risk reserve fund that will cover any cost overages for any participant. A PACE organization is responsible for the full financial risk that the cost of services required by a program participant might exceed the Medicaid capitated fee for that participant.

(h) The department shall develop and implement a coordinated plan to promote the PACE program among prospective Medicaid long term care patients in the service areas of approved PACE organizations.

(j) As soon as practicable after July 1, 2010, the department shall submit to the federal centers for Medicare and Medicaid services an amendment to the state Medicaid plan authorizing the state to implement the program of all-inclusive care for the elderly pursuant to this section. The department shall not enter into a contract with any PACE provider organization until all necessary state plan amendments or waivers are approved. An additional amendment to the state Medicaid plan shall not be required each time the department enters into a contract with a new PACE provider organization.

(k) Nothing in this section shall be construed to require a PACE organization to hold a certificate of authority as an insurer or a health maintenance organization under title 26 of the Wyoming statutes.

(m) Repealed by Laws 2015, ch. 59, § 2.

(n) No PACE organization shall withhold any necessary medical or nonmedical services to any PACE participant in order to increase the organization's profit from the Medicaid capitated payment.

(o) PACE participants may disenroll from the PACE program at any time. A PACE organization shall promptly report the identity of all disenrolled participants to the department.

42-4-122. Cooperation with paternity determination.

(a) Except as otherwise provided in subsection (b) of this section, as a condition of eligibility, or continuing

eligibility, for medical assistance under this chapter, a person who receives medical assistance shall cooperate in good faith with the department to:

(i) Establish the paternity of a child, including any proceeding to adjudicate parentage that is held pursuant to W.S. 14-2-801 through 14-2-823;

(ii) Obtain a child support obligation payment or other payments or property to which the state may have a claim, including recovery of birth costs paid by medical assistance pursuant to W.S. 14-2-1001 through 14-2-1008.

(b) The following persons are not required to cooperate with the department pursuant to subsection (a) of this section:

(i) A person who is pregnant, or who has been pregnant within the preceding sixty (60) days;

(ii) A person who has good cause to not cooperate with the department, as determined by rule promulgated pursuant to W.S. 14-2-1008;

(iii) A woman who has been pregnant within the preceding twelve (12) months. This paragraph is repealed effective March 31, 2027.

42-4-123. Repealed by Laws 2019, ch. 189, § 2.

42-4-124. Clubhouse rehabilitation services.

(a) The director of the department shall include reimbursement for clubhouse rehabilitation services within the Medicaid program.

(b) Within the limits of available funding, the department may enter into contracts with certified clubhouse providers for clubhouse rehabilitation services.

(c) On or before September 1, 2019 the department shall report to the joint labor, health and social services interim committee on information, findings and recommendations related to clubhouse rehabilitation services including information to facilitate implementation of Medicaid contracts to be entered into pursuant to this section.

(d) As used in this section, "clubhouse" means a community-based psychosocial rehabilitation program that:

(i) Has members of the program, with staff assistance, engaged in operating all aspects of the clubhouse, including food service, clerical, reception, janitorial and other member services such as employment training, housing assistance and educational support; and

(ii) Is designed to alleviate a member's emotional or behavior problems with the goal of transitioning the member to a less restrictive level of care, reintegrating the member into the community and increasing social connectedness beyond a clinical or employment setting.

ARTICLE 2 - MEDICAID BENEFIT RECOVERY

42-4-201. Action against third party; notice; subrogation.

(a) If a person who is or becomes an applicant or recipient for medical assistance under this chapter receives an injury under circumstances creating a legal liability in some third party, the applicant or recipient shall not be deprived of any medical assistance for which he is entitled under this chapter. He may also pursue his remedy at law against the third party. If the applicant or recipient recovers from the third party in any manner, including judgment, compromise, settlement or release, the state is entitled to be reimbursed for all payments made, or to be made, on behalf of the applicant or recipient under this chapter.

(b) The department shall be served by certified mail, return receipt requested, with a copy of the complaint within seven (7) days of its filing in any suit initiated pursuant to subsection (a) of this section. Any attorney who knowingly fails to serve the complaint on the department shall be reported to the state board of professional responsibility for the Wyoming state bar. The department shall be notified in writing by certified mail return receipt requested of any judgment, compromise, settlement or release entered into by any person who has been an applicant for or recipient of medical assistance under this chapter after the date of injury. If there is a settlement, compromise or release entered into by the parties the attorney general representing the director shall be made a party in all negotiations for settlement, compromise or release. The department, for purposes of facilitating compromise and settlement, may in a proper case authorize acceptance by the

state of less than the state's claim for reimbursement under this section for all current and future assistance under this chapter. Any reimbursement right created pursuant to this article shall remain in effect until the state is paid the amount authorized under this section. In addition the person paying the settlement remains liable to the state's reimbursement right unless the state through the attorney general signs the release prior to payment of an agreed settlement.

(c) If the injury causes death of the recipient, the rights and remedies in this section inure to, and the obligations are binding upon the personal representative of the deceased recipient for the benefit of his dependents.

(d) Repealed By Laws 2002, Ch. 39, § 2.

(e) If, after notice is provided in accordance with this section, the department states in writing that it will neither file an independent action nor intervene in an existing action as allowed by W.S. 42-4-114, the department's reimbursement right shall be reduced by not more than thirty-three percent (33%) for attorney's fees together with the amount of its proportionate share of costs. If the department does not provide this written statement, its right to reimbursement shall not be reduced by any share of the recipient's attorney's fees or costs.

42-4-202. Third party liability; authority; enforcement; notice; costs.

(a) When the department provides, pays for or becomes liable for medical care, it shall have a lien for the cost of the medical assistance provided upon any and all causes of action which accrue to the person to whom the care was furnished, or to the person's legal representatives, as a result of the injuries which necessitated the medical care.

(b) The department may perfect and enforce its lien by following the procedures set forth in W.S. 29-1-312 and 29-1-313, and its verified lien statement shall be filed with the appropriate clerk in the county of financial responsibility. The verified lien statement shall contain the following:

(i) The name and address of the person to whom medical care was furnished;

(ii) The date of injury;

(iii) The name and address of the vendor or vendors furnishing medical care;

(iv) The dates of the service;

(v) The amount claimed to be due for the care;

(vi) To the best of the department's knowledge, the names and addresses of all persons, firms or corporations claimed to be liable for damages arising from injuries.

(c) This section shall not affect the priority of any attorney's lien. The department shall not be subject to any limitations period referred to in title 1 or 29 of the Wyoming statutes to file its verified lien statement.

(d) The department shall be given notice of monetary claims against a person, firm or corporation that may be liable to pay part or all of the cost of medical care when the department has paid or become liable for the cost of that care. Notice shall be given as follows:

(i) Applicants for medical assistance shall notify the state or local agency of any possible claims when they submit the application. Recipients of medical assistance shall notify the department of any possible claims when those claims arise. A recipient's noncooperation in providing information to the department to assist in pursuing liable third parties shall result in denial or termination of eligibility per federal law;

(ii) An enrolled medicaid provider shall notify the department when the person has reason to believe that a third party may be liable for payment of the cost of medical care. If the person providing medical care services fails to notify the department when a third party is liable for payment of the cost of medical care and the department, because of lack of notice from the provider, does not receive reimbursement for the cost of medical care, the department may adjust the value of those claims from future payments to that provider;

(iii) An attorney representing an applicant for or a recipient of medical assistance in a claim upon which the department may have a reimbursement right under this chapter shall notify the department of its potential claim for reimbursement before filing a claim, commencing an action, or

negotiating a settlement. Any attorney who fails to notify the department of any settlement or fails to ensure the state is reimbursed, to the extent of its reimbursement right, from the proceeds of any settlement or judgment under this section shall be reported to the state board of professional responsibility for the Wyoming state bar. If the attorney knowingly failed to report and insure reimbursement to the state, the department shall have a claim for relief against the attorney for the amount of the reimbursement right under this chapter;

(iv) Insurers shall not disburse any settlement payment for a personal injury claim made to a recipient of medical assistance under this act until seven (7) working days after the department has received written notice from the insurer of the proposed settlement or judgment and failed to provide a written objection to the insurer. Failure to provide notice under this paragraph shall commence the tolling of any applicable statute of limitations.

(e) Notice given to the local agency is not sufficient to meet the requirements of paragraphs (d)(ii) through (iv) of this section.

(f) Repealed By Laws 1999, ch. 125, § 2.

42-4-203. Settlement between recipient and tortfeasor or insurer; lien not discharged; exceptions.

(a) No settlement made by and between the applicant or recipient and the tortfeasor or insurer shall discharge the right to reimbursement created pursuant to this article, against any money due or owing by such tortfeasor or insurer to the applicant or recipient or relieve the tortfeasor or insurer from liability by reason of the right to reimbursement unless the settlement also provides for the payment and discharge of the right to reimbursement and the attorney general has signed a written release as provided by W.S. 42-4-201(b).

(i) Repealed By Laws 2002, Ch. 39, § 2.

(ii) Repealed By Laws 2002, Ch. 39, § 2.

42-4-204. Department subrogated to right of recovery of applicant or recipient; utilization of personal health insurance; insurance coverage of recipients.

(a) The department shall be subrogated to any right of recovery or indemnification arising from an accident or occurrence resulting in expenditures by the department, which an applicant or recipient of medical assistance or any legally liable party has against an insurer, health insurer, self-insured plan, group health plan, service benefit plan, managed care organization, pharmacy benefit manager or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for health care items or services, including but not limited to hospitalization, pharmaceutical services, physician services, nursing services and other medical services, not to exceed the amount expended by the department for the care and treatment of the applicant or recipient. An applicant or recipient or legally liable party, by the act of applying for, or recipient receiving medical assistance, shall be deemed to have made a subrogation assignment and an assignment of claim for benefits to the department. The department shall inform an applicant of the assignments at the time of application. In addition, any entitlements from a contractual agreement with an applicant or recipient or legally liable party, a state or federal program or a claim or action against any responsible third party for medical services, not to exceed the amount expended by the department, shall be so assigned. The entitlements shall be directly reimbursable to the department by third party payors. The department may assign its right to subrogation or its entitlement to benefits to a designee or a health care provider participating in the medicaid program and providing services to an applicant or recipient, in order to assist the provider in obtaining payment for the services. A provider that has received an assignment from the department shall notify the insurer of the assignment upon rendering of services to the applicant or recipient. Failure to so notify the insurer shall render the provider ineligible for payment from the department. Once the insurer has been billed or notified the provider may not request payment through the medicaid program until a payment, denial or other explanation of benefits, not including mistakes in billing, is received from the insurer. The provider shall notify the department of any request by the applicant or recipient or his legally liable party or representative for billing information.

(b) When a recipient of medical assistance has access to personal health insurance through his employer, payment or part payment of the premium for the insurance may be made by the department when deemed appropriate by the director of the department.

(c) No individual accident policy, group accident policy, health policy, accident and health policy, medical expense policy or medical service plan contract, delivered, issued for delivery or renewed in this state on or after July 1, 1995, and no self-insured plan, managed care policy or plan, pharmacy benefit management plan or policy or other policy or plan issued by any other party that is, by statute, contract or agreement legally responsible for payment of a claim for items or services, delivered, issued for delivery or renewed in this state on or after July 1, 2007, shall contain any provision denying or limiting insurance benefits because services are rendered to an insured who is eligible for or who received medical assistance under this chapter. This section shall supersede any statutory provision to the contrary. No such policy, plan or contract, when enrolling an individual, shall take into account the individual's eligibility for medical assistance under this chapter. This subsection applies to all such policies, plans and contracts issued by any person including, but not limited to:

(i) An insurer;

(ii) A group health plan as defined in section 607(1) of the Employee Retirement Income Security Act of 1974;

(iii) A managed care organization, pharmacy benefit manager or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service;

(iv) An entity offering a service benefit plan;

(v) A self-insured plan.

(d) Medicaid shall not pay for any services provided under this chapter if the individual eligible for medical assistance has coverage for the services under an accident or health insurance policy or other source.

(e) In addition to the separate requirements set forth in W.S. 42-4-205, all health insurers, including all self-insured plans, group health plans as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care

item or service, shall agree, as a condition of doing business in the state of Wyoming, to:

(i) Provide, with respect to the individuals who are eligible for or are provided medical assistance by the department of health, information to determine the period during which the individual or the individuals' spouses or dependents may be or may have been covered by a health insurer and the nature of the coverage provided, including the name and address of the insurer and identifying number of the plan, in a manner prescribed by the secretary;

(ii) Accept the state's right of recovery and the assignment to the state of any right of an individual or other entity to payment from another party for an item or service for which payment has been made under the state plan;

(iii) Respond within sixty (60) days to any inquiry by the state regarding a claim for payment for any health care item or service that is submitted not later than three (3) years after the date of the provision of such health care item or service; and

(iv) Agree not to deny a claim submitted by the state solely on the basis of the date of submission of the claim, the type or format of the claim form, a failure to obtain required prior authorization or a failure to present proper documentation at the point of sale that is the basis of the claim, if:

(A) The claim is submitted by the state within the three (3) year period beginning on the date on which the item or service was furnished; and

(B) Any action by the state to enforce its rights with respect to the claim is commenced within six (6) years of the state's submission of the claim.

42-4-205. Insurance policy termination notification requirement.

(a) With respect to cases for which there is an assignment in effect pursuant to W.S. 42-4-204:

(i) The department, upon receipt of the health coverage information, shall notify the obligor's insuring entity that the department shall be notified thirty (30) days prior to discontinuance of coverage;

(ii) Entities providing health insurance as defined in title 26 and health maintenance organizations and prepaid health clinics as defined in W.S. 26-34-102 shall upon request by the department, provide a list of insureds residing in the state and any records and information as necessary to accomplish the purpose of this section, unless the requirement results in an unreasonable burden;

(iii) The department and the insurance commissioner appointed pursuant to W.S. 26-2-102 shall enter into a cooperative agreement for requesting and obtaining information necessary to effect the purpose and objectives of this section;

(iv) The department shall only request information from the entity providing health insurance necessary to determine whether health insurance, as defined pursuant to title 26 or those health services provided pursuant to W.S. 26-34-102, are discontinued;

(v) The department, in consultation with the department of insurance, shall promulgate rules for the development and administration of the cooperative agreement. The rules shall include the following:

(A) A method for identifying those entities subject to furnishing information under the cooperative agreement;

(B) A method for furnishing requested information; and

(C) Procedures for requesting exemption from the cooperative agreement based on an unreasonable burden to the reporting entity.

(vi) If the department notifies the insurer that it has made payments to the provider, payment of benefits or notices of denial issued by the insurer shall be made directly to the department.

(b) Upon the department receiving notice from the obligor's insuring entity that the coverage is discontinued due to cancellation for any reasons, the department shall retain that information for use in enforcing any court order requiring the obligor to provide health insurance to the individuals stated in the court order.

42-4-206. Claims against estates.

(a) If an individual receives any medical assistance pursuant to this chapter, upon the individual's death, if single, or upon the death of the survivor of a married couple, either of whom received medical assistance, the total amount paid for medical assistance rendered for the individual or the spouse shall be filed by the department of health as a claim against the estate of the individual or the estate of the surviving spouse in the court having jurisdiction to probate the estate. A claim shall be filed if medical assistance was rendered for either person under one (1) of the following circumstances:

(i) The person was fifty-five (55) years of age or older when he received medical assistance; or

(ii) The person was an inpatient in a nursing facility, intermediate care facility for people with intellectual disability or other medical institution when he received medical assistance.

(b) The claim shall be considered an expense of the last illness of the decedent. Any statute of limitations which attempts to limit the department of health to recover for medical assistance provided pursuant to this chapter shall not apply to any claim made under this section for reimbursement for the medical assistance.

(c) The claim shall include only the total amount of medical assistance rendered after the individual attains fifty-five (55) years of age or during a period of institutionalization as described in paragraph (a)(ii) of this section, and shall not include interest. A claim for medical assistance rendered for the predeceased spouse, against the estate of a surviving spouse who did not receive medical assistance, is limited to the value of the assets of the estate that were marital property or jointly owned property at any time during the marriage.

(d) If a decedent who was single, or who was the surviving spouse of a married couple, is survived by a child who has not attained twenty-one (21) years of age or is blind or permanently and totally disabled as defined by 42 U.S.C. § 1382c, no claim shall be filed against the estate.

(e) Repealed By Laws 2002, Ch. 39, § 2.

(f) The department of health shall establish procedures, in accordance with standards specified by the secretary of health and human services, under which the department of health shall waive the application of this section if application would work an undue hardship on the basis of criteria established by the secretary.

(g) As used in this section:

(i) "Asset" means as defined under W.S. 42-2-401(a)(i);

(ii) "Estate" shall include all real and personal property and other assets included within the individual's estate, as defined for purposes of this state's probate law, and includes any other real and personal property and other assets in which the individual had any legal title or interest at the time of death to the extent of that interest, including such assets conveyed to a survivor, heir or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust or other arrangement.

42-4-207. Recovery of incorrect payments; recovery of correct payments; liens.

(a) The department may through appropriate action recover any incorrect payment of medical assistance under this chapter on behalf of a recipient and may adjust any subsequent payment by an amount equal to the incorrect payment. Any recovery shall be prorated to the federal government in proportion to the amount it contributed for medical assistance rendered.

(b) In addition to subsection (a) of this section and subject to a court order for recovery, the department may file a lien upon all real and personal property of the recipient for the incorrect payment of medical assistance on his behalf.

(c) The department may file a pre-death lien upon real property of an individual for medical assistance correctly paid under this chapter to an individual:

(i) Who is an inpatient in a nursing facility, intermediate care facility for people with intellectual disability, or other medical institution; and

(ii) With respect to whom the department determines, after notice and opportunity for a hearing, cannot reasonably be expected to be discharged from the medical institution and to return home.

(d) No lien may be imposed under subsection (c) of this section on an individual's home if any of the following persons are lawfully residing in the home:

(i) The spouse of the individual;

(ii) The individual's child who is under age twenty-one (21), or is blind or disabled as defined in 42 U.S.C. 1382c; or

(iii) A sibling of the individual, who has an equity interest in the home and who was residing in the home for a period of at least one (1) year immediately before the date of the individual's admission to the medical institution.

(e) No lien imposed under subsection (c) of this section shall be subject to recovery if any of the following persons are lawfully residing in the home on a continuous basis since the date of the individual's admission to the facility or institution:

(i) A sibling of the individual who was residing in the individual's home for a period of at least one (1) year immediately before the date of the individual's admission to the facility or institution;

(ii) A child of the individual who was residing in the individual's home for a period of at least two (2) years immediately before the date of the individual's admission to the facility or institution, and who establishes by a preponderance of the evidence that he provided care to the individual which permitted the individual to reside at home rather than in a facility or institution.

(f) Any lien imposed with respect to an individual pursuant to subsection (c) of this section shall dissolve upon that individual's discharge from the medical institution and return home.

(g) Nothing in this section shall require an applicant for medical assistance under this chapter to enter into agreement

for a lien upon his real and personal property for the payment of medical assistance on his behalf.

(h) Upon sale of the property on which a lien has been imposed pursuant to subsection (c) or (j) of this section, the department shall seek recovery of the amount stated in its lien. Transfers of real or personal property on or after the look-back dates defined in 42 U.S.C. § 1396p by recipients of medical assistance under this chapter, or their spouses, without adequate consideration are voidable and may be set aside by an action in district court.

(j) The department may file a lien against the property of any estate, as defined in W.S. 42-4-206(g), of a deceased recipient for the amount of medical assistance provided while the recipient was fifty-five (55) years of age or older or while the recipient was an inpatient in a nursing facility, intermediate care facility for people with intellectual disability or other medical institution. The department shall perfect this lien by filing a notice in the county in which the real property exists. The department may file an amended lien prior to the entry of the final order closing the estate.

(k) The department may file a lien upon real property pursuant to W.S. 2-18-103(g) upon the death of the grantor. The department may file such lien regardless of whether the grantee applied for a certificate of clearance pursuant to W.S. 2-18-103(n) or filed an affidavit to establish the death of the grantor pursuant to W.S. 34-11-101.

42-4-208. Recovery for cost of health care.

(a) The department, to the extent necessary to reimburse its costs, shall be entitled to recover from any parent who:

(i) Is required by court or administrative order to provide coverage of the cost of health services to a child eligible for medical assistance under this act; and

(ii) Has received payment from a third party for the costs of such services but has not used the payments to reimburse either the other parent or guardian of the child or the provider of the services.

(b) The department shall be entitled to enforce any judgment entered pursuant to this section by garnishment or any other available statutory remedy.

(c) Claims for current and past due child support shall take priority over claims made under this section.

ARTICLE 3 - FALSE MEDICAID CLAIMS

42-4-301. Short title.

This act shall be known and may be cited as the "Wyoming Medicaid False Claims Act."

42-4-302. Definitions.

(a) As used in this act:

(i) "Claim" means any request or demand under the Medicaid program, whether under a contract or otherwise, for money, property or services that:

(A) Is presented to an officer, employee or agent of the state or a political subdivision of the state; or

(B) Is made to a contractor, grantee or other recipient, if the money or property is to be spent or used on the state's behalf or to advance a state program or interest, and if the state provides or has provided any portion of the money or property requested or demanded.

(ii) "Material statement" means a statement that affects the payment or receipt of money or property;

(iii) "This act" means W.S. 42-4-301 through 42-4-306.

42-4-303. Acts subjecting person to treble damages; costs and civil penalties; exceptions.

(a) Except as provided in subsection (c) of this section, any person who commits any of the following acts in relation to the Wyoming Medicaid program shall be liable to the state for three (3) times the amount of damages which the state sustains because of the act of that person. A person who commits any of the following acts shall also be liable to the state for the costs of a civil action brought to recover any penalties or damages provided in this subsection, and shall be liable to the state for a civil penalty of not less than one thousand dollars

(\$1,000.00) and not more than ten thousand dollars (\$10,000.00) for each violation:

(i) Knowingly presents or causes to be presented a false or fraudulent claim for payment or approval;

(ii) Knowingly makes, uses or causes to be made or used, a false record or statement material to a false or fraudulent claim;

(iii) Is a beneficiary of an inadvertent submission of a false claim to any employee, officer or agent of the state or a political subdivision of the state, or to any contractor, grantee or other recipient of state funds or funds of any political subdivision of the state, who subsequently discovers the falsity of the claim and fails to disclose the false claim and make satisfactory arrangements for repayment to the state or affected political subdivision within ninety (90) days after discovery of the false claim;

(iv) Conspires to commit a violation of paragraph (i), (ii) or (iii) of this subsection.

(b) Notwithstanding subsection (a) of this section, the court may assess not more than two (2) times the amount of damages which the state sustains because of the act in violation of subsection (a) of this section, and no civil penalty, if the court finds all of the following:

(i) The person committing the violation furnished officials of the state who are responsible for investigating false claims violations with all information known to that person about the violation within forty-five (45) days after the information is requested; and

(ii) The person has substantially cooperated with any investigation by the state.

(c) The provisions of subsections (a) and (b) of this section shall not apply to a recipient as defined by W.S. 42-1-101(a)(v). Any recipient who knowingly:

(i) Presents or causes to be presented a false or fraudulent claim shall be liable to the state for the amount of damages which the state sustains because of the claim and shall be liable for a civil penalty of not more than one thousand dollars (\$1,000.00);

(ii) Violates paragraph (i) of this subsection a second or subsequent time shall be liable to the state for three (3) times the amount of damages which the state sustains because of the claim and shall be liable for a civil penalty of not more than one thousand dollars (\$1,000.00).

42-4-304. Investigations and prosecutions; powers of prosecuting authority; remedies for retaliation; venue; no private right of action.

(a) The Medicaid fraud control unit created by W.S. 42-4-403 or a district attorney may investigate alleged violations of W.S. 42-4-303(a) and (c). If the Medicaid fraud control unit or district attorney finds that a person has violated or is violating W.S. 42-4-303(a) or (c), the unit or district attorney may bring a civil action under this section against that person.

(b) Any employee, contractor or agent of a person being investigated for a violation of W.S. 42-4-303(a) shall be entitled to recover all economic damages suffered if that employee, contractor or agent is discharged, demoted, suspended, threatened, harassed or in any other manner retaliated against in the terms and conditions of employment because of lawful acts taken in good faith by the employee or others in an action reported, filed or investigated under this act. An action by an employee, contractor or agent under this subsection shall not be brought more than three (3) years after the date when the retaliation occurred. A person may bring an action in the appropriate district court for the relief provided in this subsection. This subsection shall not otherwise be construed to create a private cause of action for violations of this act and is limited to the remedies expressly created by this subsection related to employment retaliation.

(c) Except as provided in subsection (b) of this section, any action under this act may be brought in the district court of any county in which the defendant, or any of them, resides. If the defendant is not a resident of the state of Wyoming, the action shall be brought in the first judicial district court in Laramie County.

(d) Except as provided in subsection (b) of this section, nothing in this act shall be construed to create a private cause of action.

(e) The remedies provided in this act are separate from and additional to any remedies available under the State Government Fraud Reduction Act.

42-4-305. Limitation of actions; retroactivity; burden of proof.

(a) A civil action under W.S. 42-4-304(a) shall not be brought more than six (6) years after the date on which the violation was committed or more than three (3) years after the date when facts material to the right of action are known or reasonably should have been known by the official of the state charged with responsibility to act in the circumstances, whichever occurs last, provided that in no event shall a civil action be brought more than seven (7) years after the date on which the violation is committed.

(b) In any action brought under W.S. 42-4-304(a), the state shall be required to prove all essential elements of the cause of action, including damages, by clear and convincing evidence.

(c) Notwithstanding any other provision of law, a guilty verdict rendered in a criminal proceeding charging false statements or fraud is admissible in any civil action which involves the same transaction as in the criminal proceeding and which is brought under W.S. 42-4-304.

42-4-306. Remedies under other laws; liberality of construction; joint and several liability.

(a) The provisions of this act are not exclusive, and the remedies provided for in this act shall be in addition to any other remedies provided for in any other law or available under common law.

(b) Liability pursuant to this act is joint and several for any violation done by two (2) or more persons.

ARTICLE 4 - MEDICAID FRAUD CONTROL

42-4-401. Short title.

This act may be cited as the "Wyoming Medicaid Fraud Control Act".

42-4-402. Definitions.

(a) As used in this act:

(i) "Claim" means as defined in W.S. 42-4-302(a)(i);

(ii) "Provider" means a person who furnishes services or supplies for which payment is claimed under Medicaid;

(iii) "Record" means information in physical or electronic form relating to:

(A) The treatment or care of any patient;

(B) A service or supply provided to a Medicaid recipient;

(C) Rates paid for a service or supply;

(D) Any other information required to be kept by rule of the Medicaid program.

(iv) "Unit" means the Medicaid fraud control unit created by this act to investigate and prosecute fraud, waste, abuse, bribery, kickback and related cases under Medicaid;

(v) "This act" means W.S. 42-4-401 through 42-4-412.

42-4-403. Medicaid fraud control unit created; duties.

(a) The Medicaid fraud control unit is recognized and continued in existence within the office of the attorney general. The unit shall conduct a statewide program for investigating and prosecuting violations of all applicable state laws pertaining to fraud in the administration of the Medicaid program and the provision of services or supplies, or the activities of providers of services or supplies, under the state Medicaid plan. The unit may also conduct criminal investigations and prosecutions relating to patient abuse, neglect, exploitation and other violations of law, if the violation is primarily connected to Medicaid.

(b) The office of the attorney general shall employ attorneys, auditors, agents and other personnel which are necessary to carry out the duties specified in this act in an effective and efficient manner. Agents employed under this subsection shall have the qualifications and powers of an agent under W.S. 9-1-611(b)(i).

(c) The unit may file criminal charges without consultation with another person or entity outside the office of the attorney general. Before the filing of criminal charges under this act, the unit may consult with the district attorney of the judicial district in which the prosecution would take place. If the district attorney, after consultation, concurs with the decision to file criminal charges, the unit may refer the case to the district attorney. A district attorney may request that the unit assign an attorney to assist with prosecution under this act.

42-4-404. Access to records.

(a) Notwithstanding any other provision of law, the unit shall have full access to all records held by a provider or by another person or entity acting on the provider's behalf, if the unit determines that such information is material to its duties under this act. A provider, or another person or entity acting on the provider's behalf, shall promptly comply with a request from the unit for access to records.

(b) The unit shall avoid disclosure of personally identifiable information concerning any patient received in the course of an investigation, except as authorized by this section. The unit may transmit personally identifiable information to authorized persons, consistent with federal law, including governmental entities responsible for oversight of the health care system, benefit programs or the regulation of health care facilities or health care providers. The unit may also disclose information under this section as otherwise permitted or required by law.

(c) No provider or other person or entity holding records required to be made available to the unit under this section may refuse to provide access on the basis that release would violate any right of privacy, privilege against disclosure or use or any other grounds for nondisclosure.

(d) Nothing in this section shall be interpreted to limit the authority of the unit to use other legal processes to conduct investigations and prosecutions authorized by this act or other provisions of law.

42-4-405. Reporting to unit.

The department of health, department of family services, health care licensing boards, state agencies and the agents, contractors and subcontractors of these entities shall refer to the unit all cases where reasonable cause likely exists that fraud, waste, abuse, bribery or kickbacks relating to Medicaid has occurred, is occurring or will occur, as well as suspected cases of patient abuse, neglect or exploitation under Medicaid.

42-4-406. Fraud and false statements; criminal penalty.

(a) In relation to the delivery of or payment for services or supplies under Medicaid, a person shall not knowingly, in whole or in part:

(i) Make or cause to be made a false or fraudulent claim;

(ii) Deliberately conceal a material fact;

(iii) Make or cause to be made a false statement or misrepresentation which will be used by another person;

(iv) Execute a scheme or artifice to commit fraud.

(b) A person who violates subsection (a) of this section is guilty of:

(i) A misdemeanor punishable by imprisonment of not more than six (6) months, a fine of not more than seven hundred fifty dollars (\$750.00), or both, if the amount of the claims for services or supplies under Medicaid is less than one thousand dollars (\$1,000.00); or

(ii) A felony punishable by imprisonment for not more than ten (10) years, a fine of not more than ten thousand dollars (\$10,000.00), or both, if the amount of the claims for services or supplies under Medicaid is one thousand dollars (\$1,000.00) or more.

(c) The department of health shall ensure that the following documents contain a statement, under penalty of perjury and signed by the responsible provider, that all matters stated therein are true and accurate:

(i) An application to become a Medicaid provider;

(ii) All reports stating income or expenses upon which rates of payment by the department of health may be based; and

(iii) Each invoice for payment of a service or supply provided to a person eligible for Medicaid.

(d) A person commits perjury if the person signs or submits, or causes to be signed or submitted a statement under subsection (c) of this section, knowing that the application, report or invoice contains information that is false, in whole or in part. Perjury under this subsection shall be punished as specified in W.S. 6-5-301(b).

42-4-407. Kickbacks, bribes, undisclosed payments, referral fees and illegal copayments; criminal penalty; exception.

(a) A person shall not knowingly, in whole or in part:

(i) Act on behalf of a provider to purchase or lease a service or supply for which payment may be made, in whole or in part, under Medicaid and then solicit or accept anything of additional value in connection with the purchase or lease;

(ii) Sell or lease to a provider a service or supply for which payment may be made, in whole or in part, under Medicaid, and offer, transfer or pay anything of additional value in connection with the sale or lease;

(iii) Refer an individual to a provider for the provision of a service or supply for which payment may be made, in whole or in part, under Medicaid, and solicit or accept anything of value in connection with the referral;

(iv) Act on behalf of a provider to charge, solicit, accept or receive anything of value in addition to the amount payable for a service or supply under Medicaid.

(b) A violation of subsection (a) of this section is a felony punishable by imprisonment of not more than five (5) years, a fine of not more than ten thousand dollars (\$10,000.00), or both.

(c) A person does not commit a violation of paragraph (a)(i) or (ii) of this section in cases where the additional value transferred is a refund or discount made in the ordinary

course of business and is reflected by the records of the person within a reasonable period of time after the transfer of value.

42-4-408. Failure to maintain records; destruction of records; penalty.

(a) A person, after submitting a claim or receiving a payment for a service or supply under Medicaid, shall not knowingly fail to maintain records required under Medicaid, including records that fully disclose the nature of the services or supplies provided to a recipient.

(b) A person who violates subsection (a) of this section is guilty of:

(i) A misdemeanor punishable by imprisonment for not more than thirty (30) days, a fine of not more than seven hundred fifty dollars (\$750.00), or both, if:

(A) The claims for which records were not maintained are less than twenty-five percent (25%) of the Medicaid claims submitted by the provider in any consecutive three (3) month period; and

(B) The amount of the claims for which records were not maintained is five thousand dollars (\$5,000.00) or more.

(ii) A misdemeanor punishable by imprisonment for not more than six (6) months, a fine of not more than one thousand dollars (\$1,000.00), or both, if:

(A) The claims for which records were not maintained are twenty-five percent (25%) or more of the Medicaid claims submitted by the provider in any consecutive three (3) month period; and

(B) The amount of the claims for which records were not maintained is five thousand dollars (\$5,000.00) or more.

(iii) A felony punishable by imprisonment for not more than five (5) years, a fine of not more than ten thousand dollars (\$10,000.00), or both, if:

(A) The person intended to defraud Medicaid and the claims for which records were not maintained are twenty-five

percent (25%) or more of the Medicaid claims submitted by the provider in any consecutive three (3) month period; and

(B) The amount of the claims for which records were not maintained is five thousand dollars (\$5,000.00) or more.

42-4-409. Aggregation of claims in certain cases.

The amount of claims relating to violations of this act through a common scheme, or based on the same transaction or occurrence, may be aggregated to determine the level of penalty under this act, whether or not the claims were made as part of the same claim under Medicaid.

42-4-410. Suspension or exclusion as provider.

(a) The department of health or the department of family services may suspend or exclude a provider from providing services and supplies under Medicaid if:

(i) The department determines that the provider has committed an offense under this act or the Wyoming Medicaid False Claims Act, whether or not a criminal prosecution is brought under this act or any civil action is brought under the Wyoming Medicaid False Claims Act; or

(ii) A provider fails to provide the unit with access to records pursuant to W.S. 42-4-404(a).

(b) Any term of suspension or exclusion under this section, which may be permanent, shall be determined by the department of health or the department of family services.

(c) The department of health and the department of family services may adopt rules necessary to implement this section.

42-4-411. Provisions of act not exclusive remedies.

The provisions of this act shall not be exclusive and do not preclude the use of any other criminal or civil remedy as authorized by law.

42-4-412. Rules.

The attorney general, in consultation with the department of health, may adopt rules to implement W.S. 42-4-401 through 42-4-409 and 42-4-411.

CHAPTER 5 - FAMILY PLANNING AND BIRTH CONTROL

42-5-101. Provision of information and services; refusal to accept.

(a) The department of health may provide and pay for family planning and birth control information and services including interviews with trained personnel, distribution of literature, referral to a licensed physician for consultation, examination, tests, medical treatment and prescription and to the extent prescribed, the distribution of rhythm charts, drugs, medical preparation, contraceptive devices and similar products, to any person who may benefit from this information and these services. Information and services shall be provided in a language understood by the recipient.

(b) Any medical service shall be performed by a licensed physician.

(c) The right to receive public assistance and social services or any other public benefit shall not be affected by a refusal to accept family planning and birth control services. Each person offered family planning and birth control services shall be advised of this subsection both orally and in writing.

(d) Any person may refuse to accept the duty of offering family planning and birth control services to the extent the duty is contrary to his personal or religious beliefs. The refusal shall not be grounds for:

- (i) Any disciplinary action;
- (ii) Dismissal;
- (iii) Any departmental transfer;
- (iv) Any other discrimination in employment;
- (v) Suspension from employment; or
- (vi) Any loss in pay or other benefits.

42-5-102. Statutory interpretation.

(a) Nothing in W.S. 42-5-101 shall be interpreted to:

(i) Interfere with a person's religious beliefs;

(ii) In any way abridge the right to accept or refuse family planning and birth control services;

(iii) Impose practices offensive to a person's moral standards; or

(iv) Restrict self-determination in the procreation of children.

CHAPTER 6 - LONG TERM CARE CHOICES PROGRAM

42-6-101. Short title.

This act shall be known and may be cited as the "Wyoming Long Term Care Choices Act".

42-6-102. Definitions.

(a) As used in this act:

(i) "Adult foster care" means care in a home licensed as an adult foster home and care provided to a resident of the home while temporarily away from the adult foster home;

(ii) "Adult foster care home" means any family home or facility in which residential care is provided in a homelike environment for five (5) or fewer adults who are not related to the provider by blood, marriage or adoption, except in special circumstances. "Adult foster care home" does not include any residential facility otherwise licensed or funded by the state of Wyoming. The homes shall be regulated in accordance with W.S. 35-2-901 through 35-2-913 and this act which shall govern in case of conflict;

(iii) "Alternative eldercare home" means a facility and program which:

(A) Provides services and care at the highest level required by a resident and as permitted under the applicable facility;

(B) Shall be licensed as a health care facility pursuant to W.S. 35-2-901 through 35-2-913;

(C) Creates communities that allow long-term residents to develop lasting relationships with other residents and staff;

(D) Maintains residences as units independent from each other;

(E) Provides, at a minimum, a private bedroom and bathroom for each resident;

(F) Provides services to Medicaid supported residents at the Medicaid reimbursement rates;

(G) Maintains all common spaces within the house, including secured exterior space, accessible and open to all residents during waking hours;

(H) Provides an office space for a nurse within each house;

(J) Provides a common area in each house including a seating area;

(K) Provides public and staff bathroom facilities;

(M) Creates a residential home environment in all aspects, using residential materials and designs appropriate to the style of the community;

(N) Is committed to a restraint free environment;

(O) Implements a culture of learning and participation by the residents and honors the elder hood stage of life.

(iv) "Assisted living facility" means as defined in W.S. 35-2-901(a)(xxii);

(v) "Department" means the department of health;

(vi) "Home medical testing" means medical testing designed to be done in the home of the person being tested by a

person who is not a licensed health care professional and includes but is not limited to testing done using a home blood pressure monitor or a home diabetes management blood sugar monitor;

(vii) "Long term care assessment" means a form and an assessment process conforming with relevant federal regulations and designed to measure the abilities and disabilities of a person in the activities of daily living to determine the person's need for long term care. As of January 1, 2007 the department of health form LT-101 entitled "Assessment of Medical Necessity for Long Term Care" and the assessment needed to complete it shall be the long term care assessment;

(viii) "Medicaid" means the program administered by the state pursuant to the Wyoming Medical Assistance and Services Act and this act and partly funded by the federal government pursuant to Title XIX of the federal Social Security Act;

(ix) "Nursing home" means a nursing care facility as defined in W.S. 35-2-901(a)(xvi) and licensed pursuant to Wyoming Statutes, article 9, chapter 2, title 35;

(x) "Residential care" means the provision of room and board and services that assist the resident in activities of daily living including but not limited to bathing, dressing, grooming, eating, medication management, incontinence care, home medical testing, money management or recreation;

(xi) "This act" means W.S. 42-6-101 through 42-6-109.

42-6-103. Rulemaking; guidance.

The department is authorized to promulgate rules and regulations to implement this act. The rules and regulations shall seek to implement the objectives of this act by expanding the long term care system to one emphasizing consumer choice and home, home like and community based care alternatives.

42-6-104. Alternative long term care home pilot programs authorized.

(a) Three (3) pilot program grants are authorized to study the feasibility of innovation in long term care facilities. Eligible recipients shall include cities, counties and any entity planning for long term care needs or providing long term

care including private nonprofit and private for profit entities. The department shall solicit proposals for the grants through a request for proposals developed in consultation with the advisory council on aging. The department, in consultation with the council, shall select the recipients from the proposals received. The department shall negotiate any specific provisions of the grant award needed and shall administer the grants. In selecting the recipients, the council shall:

(i) Consider the extent to which the proposal moves the staff of the facility to a more patient centered culture;

(ii) Consider one (1) project to reconfigure an existing nursing home to achieve a resident-centered cultural change;

(iii) Fund one (1) study relating to the creation of an alternative eldercare home, as defined in W.S. 42-6-102(a)(iii), provided that an acceptable project proposal is received in response to the request for proposals;

(iv) Fund one (1) study relating to the creation of an alternative eldercare home, as defined in W.S. 42-6-102(a)(iii), which shall require that the home:

(A) Maintains residences as units independent from other facilities such that there is no physical connection or shared roof structures between houses;

(B) Provides a secured exterior patio or garden with covered seating for each house accessible by all residents including those with wheelchairs and assistive devices;

(C) Provides for locked storage of hazardous materials and control of kitchen access during high traffic periods of meal preparation and clean-up;

(D) Provides a den in each house to accommodate television viewing and limited overnight guests;

(E) Implements a self-managed work team approach to in-house and clinical support staffing. Each house shall have its own core in-house staffing that is specific and dedicated to a single house;

(F) Uses a home base facility for the clinical support team members that is outside and separate from the house; and

(G) Maintains a lift free environment by providing ceiling lifts in each resident's bedroom and bathroom.

(v) Consider the extent to which there is a market for the proposed facility or the extent to which people in need of long term care are likely to choose the proposed facility; and

(vi) Consider the extent to which the proposed pilot project will determine the effectiveness of its approach to elder care in a timely manner.

(b) Each grant proposal shall include plans for a local or applicant match of twenty-five percent (25%) of the grant amount.

(c) For applicants that have completed any appropriate needs study or market study, the grant funding may be used for design and development of the facility and the organization which will operate it. If this is done, the grant recipient shall agree to accept Medicaid clients in the facility without discrimination.

(d) The department is directed to work with grant recipients in the development of rules and regulations which are compatible with the culture of the homes and which will assure appropriate licensure for the care provided and the needs of the elder residents. The department shall inform the joint labor, health and social services interim committee if legislation is needed to authorize any necessary rules and regulations.

(e) As a condition of receiving the grants, each grantee shall agree to provide training and reports to other parties in the state interested in innovative long term care approaches.

42-6-105. Adult foster care homes; licensure; suspension or revocation.

(a) The department may initiate and license an adult foster care pilot project subject to the following:

(i) The applicant shall pay a one-time fee of one hundred dollars (\$100.00) which shall be deposited in the general fund;

(ii) The department, a public health nurse or other employee of a local department of health shall complete an inspection of the proposed adult foster care home;

(iii) The proposed home shall comply with all state and local building, sanitation, utility, fire and zoning codes applicable to single family dwellings;

(iv) Repealed by Laws 2015, ch. 176, § 2.

(v) Repealed by Laws 2015, ch. 176, § 2.

(vi) The pilot program shall consist of no more than ten (10) adult foster care homes. At least three (3) of the homes shall be in counties with a population of thirty thousand (30,000) or less.

(b) The department may, after notice and opportunity for hearing, revoke or suspend any license issued pursuant to this section, may prohibit a facility from accepting new resident clients, may place conditions on the continuation of a license, or may require a facility to take specified remedial actions within a specified time, if:

(i) There is a threat to the health, safety or welfare of any resident client;

(ii) There is credible evidence of abuse, neglect or exploitation of any resident client;

(iii) The facility is not operated in compliance with this act or any rules and regulations promulgated pursuant to this act.

(c) If, in the professional judgment of the state health officer, there is a clear and present threat to the health or safety of a resident client, the state health officer may close an adult foster care home and transfer the residents to another place. The department shall also initiate proceedings pursuant to subsection (b) of this section within three (3) working days.

(d) The department shall complete a criminal records check on any individual employed by adult foster care homes and on any

individual, other than a resident client or a resident client's spouse, who at the time of licensure is expected to live in the adult foster care home or who, after licensure, lives or comes to live in the adult foster care home. The department may refuse to license a facility or prohibit the individual from living in the facility if he has been convicted of a felony indicating he may abuse a resident or steal from a resident.

(e) The department shall promulgate rules and regulations consistent with this act to govern the pilot project.

(f) Repealed by Laws 2015, ch. 59, § 2.

42-6-106. Home and community based waiver program expanded; requirements.

(a) Repealed By Laws 2013, Ch. 117, § 2.

(b) The department is authorized to increase the provider reimbursement levels by an amount up to three dollars (\$3.00) per hour for hourly services or seventeen and six-tenths percent (17.6%) above the prevailing rate for nonhourly services as of December 1, 2006. The department shall report to the joint labor, health and social services interim committee by November 1, 2007 the extent to which reimbursement improvements and any other changes made have improved the availability of home health care services and any additional remedies that may be needed. The length of the report shall not exceed one thousand (1,000) words plus any appropriate charts and graphs. Additional reports may be made from time to time as the need arises.

(c) The department shall set goals for expanding the number of Medicaid home and community based clients in self directed budget options and shall report progress toward those goals to the joint labor, health and social services interim committee no later than November 1, 2007, November 1, 2008 and November 1, 2009. The department shall allow these options to be managed by persons designated to do so in advanced health care directives.

(d) Consistent with approved budgets, the department shall make available a pool of state funds to meet transitional needs of clients moving from a more restrictive to a less restrictive environment in circumstances where Medicaid funds are not available due to federal restrictions. If sufficient funds are available, these state funds may also be used to meet short term needs of clients seeking to avoid placements in more restrictive

environments. The department shall govern the expenditure of these funds through contracts, policies and rules and regulations as needed.

42-6-107. Assisted living expansion; reimbursement increase.

The department shall seek federal approval to increase the number of allowed slots in the assisted living Medicaid waiver from one hundred forty-six (146) to one hundred sixty-eight (168) slots.

42-6-108. Adult day care.

The department shall investigate adult day care providers in Wyoming with respect to access, rates, administration of rules and regulations and their impact on providers and clients, and shall report its findings to the joint labor, health and social services interim committee and to the advisory council on aging. The report shall not exceed two thousand (2,000) words in length plus appropriate charts and graphs.

42-6-109. Aging and disability resource centers.

(a) The department is authorized, using competitive grants and contracts, to fund a statewide network of aging and disability resource centers.

(b) Locations of the aging and disability resource centers shall be determined by the department of health, aging division. In selecting locations for aging and disability resource centers, the department of health, aging division, shall require a degree of local community funding, which may include in kind contributions, for a center.

(c) The purpose of each center shall be to create a single, coordinated system of information and assistance for all persons seeking long term support. Each center shall assist eligible persons in making informed decisions about health care access and long term care service and support options and shall serve as a referral agency to the long term care support system. Centers shall provide information and assistance to individuals needing either public or private resources, professionals seeking assistance on behalf of their clients and individuals planning for their future long term care needs.

(d) Repealed by Laws 2015, ch. 59, § 2.

CHAPTER 7 - LONG-TERM CARE PARTNERSHIP PROGRAM

42-7-101. Short title.

This act may be cited as the "Wyoming Long-Term Care Partnership Program Act."

42-7-102. Definitions.

(a) As used in this act:

(i) "Agency" means the department of health;

(ii) "Asset disregard" means, with respect to qualification for state Medicaid benefits, the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified long-term care insurance partnership policy;

(iii) "Department" means the department of insurance;

(iv) "Medicaid" means the program administered by the state pursuant to the Wyoming Medical Assistance and Services Act and this act and partly funded by the federal government pursuant to title XIX of the federal Social Security Act;

(v) "Qualified long-term care insurance partnership policy" means a policy that meets all of the following requirements:

(A) The policy covers an insured who was a resident of Wyoming when coverage first became effective under the policy;

(B) The policy is a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986 issued not earlier than the effective date of the state plan amendment;

(C) The director of the department certifies that the policy meets the model regulations and requirements of the national association of insurance commissioners model specified in paragraph (5) of title VI, section 6021 of the federal Deficit Reduction Act of 2005; and

(D) If the policy is sold to an individual who:

(I) Has not attained age sixty-one (61) as of the date of purchase, the policy provides compound annual inflation protection;

(II) Has attained age sixty-one (61) but has not attained age seventy-six (76) as of such date, the policy provides some level of inflation protection; or

(III) Has attained age seventy-six (76) as of such date, the policy may, but is not required to, provide some level of inflation protection.

(vi) "State plan amendment" means a state Medicaid plan amendment made with the approval of the federal department of health and human services that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified long-term care insurance partnership policy.

42-7-103. Wyoming long-term care partnership program established.

(a) In accordance with title VI, section 6021 of the federal Deficit Reduction Act of 2005, there shall be established the Wyoming long-term care partnership program, to be administered by the agency with the assistance of the department, to provide incentives for individuals to insure against the costs of providing for their long-term care needs by creating a mechanism for individuals to qualify for coverage of the cost of their long-term care needs under Medicaid without first being required to substantially exhaust their resources.

(b) The agency shall:

(i) Before January 1, 2010, or as soon thereafter as possible, make application to the federal department of health and human services for a state plan amendment to establish that, if an individual is a beneficiary of a long-term care partnership program certified policy, the total assets an individual owns and may retain under Medicaid and still qualify for benefits under Medicaid at the time the individual applies for long-term care benefits are increased by one dollar (\$1.00) for each one dollar (\$1.00) of benefit paid out under the

individual's long-term care partnership program certified insurance policy;

(ii) Provide information and technical assistance to the department on the department's role in assuring that any individual who sells a qualified long-term care insurance partnership policy receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

(c) The department may not impose any requirement affecting the terms of benefits of a policy under the partnership program unless the department imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

(d) The issuers of qualified long-term care partnership policies in Wyoming shall provide regular reports to the secretary of the federal department of health and human services, in accordance with federal regulations.

(e) Reciprocity between the program and other state programs shall be subject to the following:

(i) Any individual who has purchased a partnership policy in any participating state, who has received benefits under the policy and who applies for Medicaid in a participating state other than the one in which the policy was issued shall receive an asset disregard in an equal dollar amount to the benefits received under the policy;

(ii) The asset disregard procedure and calculation shall be the same for every individual with a partnership policy who applies for Medicaid in the participating state, without regard to whether the policy was purchased in another state or the date the policy was purchased;

(iii) An amount equal to the benefits received under the partnership policy shall be exempt from Medicaid estate recovery provisions; and

(iv) If a person moves from the state in which the person's partnership policy was issued, later applies for Medicaid in another participating state and is determined to be eligible using a partnership asset disregard, the partnership asset disregard shall not be revoked upon eligibility

redetermination should the state subsequently decide to become exempt from the reciprocity agreement.

42-7-104. Administration.

(a) The agency and the department are authorized to adopt rules to implement and administer the provisions of this act.

(b) The agency and department shall comply with all federal rules developed in accordance with title VI, section 6021 of the federal Deficit Reduction Act of 2005, regarding data reporting, reciprocity with other states that develop long-term care insurance partnership programs, and any other matters, and shall have the authority to adopt regulations relative to the provisions of any federal rules and their administration.

CHAPTER 8 - NURSING CARE FACILITY ASSESSMENT ACT

42-8-101. Short title.

This article shall be known and may be cited as the "Wyoming Nursing Care Facility Assessment Act."

42-8-102. Definitions.

(a) As used in this article:

(i) "Account" means the nursing care facility assessment account created under W.S. 42-8-103;

(ii) "Department" means the department of health;

(iii) "Fiscal year" means the twelve (12) month period beginning October 1 and ending September 30;

(iv) "Medicaid" means as defined in W.S. 42-7-102(a)(iv);

(v) "Medicare resident day" means a resident day funded by the Medicare program, a Medicare advantage or special needs plan or by the Medicare hospice program;

(vi) "Net patient service revenue" means gross inpatient revenues from services provided to nursing care facility patients less reductions from gross inpatient revenue resulting from an inability to collect payment of charges. Inpatient care revenue excludes nonpatient care revenue such as

beauty and barber, vending income, interest and contributions, revenues from the sale of meals and all outpatient revenues. Reductions from gross revenue includes bad debts, contractual adjustments, uncompensated care, discounts and adjustments and other revenue deductions;

(vii) "Nursing care facility" means a facility providing nursing care, but does not include a facility solely providing assisted living care, a facility solely providing rehabilitative services or a facility solely providing a combination of assisted living care and rehabilitative services;

(viii) "Resident day" means a calendar day of care provided to a nursing facility resident, including the day of admission and excluding the day of discharge, provided that one (1) resident day shall be deemed to exist when admission and discharge occur on the same day;

(ix) "Upper payment limit" means the limitation established pursuant to 42 C.F.R. 447.272 that disallows federal matching funds when state Medicaid agencies pay certain classes of nursing care facilities an aggregate amount for services furnished by that class of nursing care facilities that would exceed the amount that would be paid under Medicare payment principles.

42-8-103. Nursing care facility assessment account.

(a) The nursing care facility assessment account is created.

(b) The state treasurer shall invest amounts deposited within the account in accordance with law, and all investment earnings shall be credited back to the account.

(c) The account shall consist of:

(i) Amounts collected or received by the department from nursing care facility assessments under this article;

(ii) All federal matching funds received by the department as a result of expenditures made by the department attributable to the account;

(iii) Any interest or penalties levied in conjunction with the administration of this article.

(d) The account is created for the purpose of receiving funds as specified in this section. Collected assessment funds shall be used to secure federal matching funds available through the state Medicaid plan, which shall be used to make Medicaid payments for nursing care facility services which exceed the amount of nursing care facility Medicaid rates, in the aggregate, as calculated in accordance with the approved state Medicaid plan in effect on October 1, 2010. The fund shall be used exclusively for the following purposes:

(i) To pay administrative expenses incurred by the department or its agent in performing the activities authorized by this article, provided that such expenses shall not exceed a total of one percent (1%) of the aggregate assessment funds collected in the fiscal year;

(ii) To increase nursing care facility payments to fund covered services to Medicaid beneficiaries within Medicare upper payment limits, as negotiated with the department. The upper payment limit for private nursing care facilities, state government-owned facilities and nonstate government-owned nursing facilities shall be calculated by the department using the higher of the cost-based or prospective payment system approach in accordance with the provisions of 42 C.F.R. 447.272;

(iii) To repay the federal government any excess payments made to nursing facilities if the state plan, after approval by the federal centers for Medicare and Medicaid services, is subsequently disapproved for any reason and after the state has appealed. Nursing care facilities shall refund the excess payments to the assessment account. The department shall return the excess payments to the federal government and nursing care facility providers in the same proportion as the original financing. Individual nursing care facilities shall be reimbursed based on the proportion of the individual nursing care facility's assessment to the total assessment paid by nursing care facilities. If a nursing care facility is unable to refund payments as provided in this paragraph, the department shall develop a payment plan and deduct amounts from future Medicaid payments. The department shall refund the federal government for the federal portion of those overpayments; or

(iv) To make quarterly adjustment payments as provided in W.S. 42-8-108.

42-8-104. Assessments.

(a) Each nursing care facility shall pay the nursing care facility assessment to the account in accordance with this article.

(b) The aggregated amount of assessments for all nursing facilities during a fiscal year shall be the lesser of the amount necessary to fund the provisions of this article or the maximum amount that may be assessed pursuant to the indirect guarantee threshold as established pursuant to 42 C.F.R. 433.68(f)(3)(i). The department shall determine the assessment rate prospectively for the applicable fiscal year on a per-resident-day basis, exclusive of Medicare resident days. The per-resident-day assessment rate shall be uniform. The department shall promulgate rules for facility reporting of non-Medicare resident days and for payment of the assessment.

(c) The department shall collect, and each nursing care facility shall pay, the assessment under this section on a quarterly basis. The initial payment shall be due not later than forty-five (45) days after the state plan has been approved by the federal centers for Medicare and Medicaid services unless a later date is set by the department. Subsequent payments are due not later than forty-five (45) days after the end of each calendar quarter.

(d) Nursing care facility operators may increase their charges to incorporate the cost of paying the assessment under this section, but shall not create a separate line-item charge on the bill reflecting the assessment.

42-8-105. Approval of state plan.

(a) The department shall seek necessary federal approval in the form of state plan amendments in order to implement the provisions of this article.

(b) The department shall adopt rules and regulations necessary to implement the provisions of this article or obtain approval of the state plan amendments.

42-8-106. Multiple facilities.

If a person conducts, operates or maintains more than one (1) nursing care facility licensed by the department, the person shall pay the assessment for each nursing care facility separately.

42-8-107. Penalties for failure to pay assessment.

(a) If a nursing care facility fails to pay an assessment when due under this article, there shall be added to the assessment a penalty equal to five percent (5%) of the amount of the assessment that was not paid when due. The penalty under this section may be waived by the department for good cause. Any payments after a penalty is assessed under this section shall be credited first to unpaid assessment amounts rather than to penalty or interest amounts, beginning with the most delinquent installment.

(b) In addition to the penalty under subsection (a) of this section, the department may implement any of the following remedies for failure of a nursing care facility to pay its assessment when due under this article:

(i) Withhold any medical assistance reimbursement payments until the assessment is paid;

(ii) Suspend or revoke the nursing care facility's license; or

(iii) Develop a plan that requires the nursing care facility to pay any delinquent assessment in installments.

42-8-108. Quarterly adjustment payments.

(a) Each nursing facility is eligible for quarterly adjustments as provided in this section.

(b) The department shall determine the number of days that nursing care facility services were paid for by the Wyoming medical assistance program for the applicable annual cost report. That number of days shall be utilized by the department to determine the nursing care facility adjustment payment. Adjustment payments shall be paid by the department on a quarterly basis to reimburse covered Medicaid expenditures in the aggregate within the upper payment limit. Each quarterly payment shall be made not later than thirty (30) days after the end of the calendar quarter with the initial adjustment payment due not later than thirty (30) days after the approval by the federal centers for Medicare and Medicaid services of the state's plan reflecting facility adjustment payments.

42-8-109. Discontinuation of the assessment and quarterly adjustment payments.

(a) The assessment imposed by this article shall be discontinued if:

(i) The state plan amendment reflecting the quarterly nursing care facility adjustment payments under W.S. 42-8-108 is not approved by the federal centers for Medicare and Medicaid services. The department may modify the rate adjustment provisions as necessary to obtain the federal centers for Medicare and Medicaid services approval if such changes do not exceed the authority and purposes of this article;

(ii) The department reduces rates to a level less than the rates effective on October 1, 2010 plus revenue increases from the account, including matches by federal financial participation;

(iii) The department or any other state agency attempts to utilize the money in the account for any use other than permitted by this article;

(iv) If federal financial participation to match assessments under this article becomes unavailable under federal law. In such case, the department shall terminate the imposition of assessments beginning on the date the federal statutory, regulatory or interpretive change takes effect.

(b) If collection of the assessment is discontinued as provided in this section, quarterly adjustment payments shall be discontinued and any amount in the account shall be returned to the nursing care facility from which the assessment was collected on the same basis as it was collected.

CHAPTER 9 - PRIVATE HOSPITAL ASSESSMENT ACT

42-9-101. Short title.

This chapter shall be known and may be cited as the "Wyoming Private Hospital Assessment Act."

42-9-102. Definitions.

(a) As used in this chapter:

(i) "Account" means the private hospital assessment account created by W.S. 42-9-103;

(ii) "Department" means the department of health;

(iii) "Fiscal year" means the twelve (12) month period beginning October 1 and ending September 30;

(iv) "Medicaid" means the medical assistance program established by title XIX of the federal Social Security Act and administered in this state by the department pursuant to the Wyoming Medical Assistance and Services Act;

(v) "Medicare cost report" means the annual hospital cost report as determined by the centers for medicare and medicaid services and as reported to the health care cost report information system;

(vi) "Net hospital patient revenue" means gross hospital revenue as reported on the most recently filed medicare cost report, excluding estimated nonhospital ancillary revenue, multiplied by the hospital's ratio of total net to gross revenue. The department shall establish a procedure to reconcile filed cost report information with information from the settled cost report. If a hospital does not file a medicaid cost report, the department shall establish a procedure to determine what the hospital would have reported as net patient hospital revenue if the hospital had filed a medicaid cost report;

(vii) "Private hospital" means those institutions licensed by the department as hospitals which are not owned or operated by the state or any city, town, county, special district or other political subdivision of the state or local government;

(viii) "Quarterly adjustment payment" means the payment made to private hospitals pursuant to W.S. 42-9-106;

(ix) "Upper payment limit" means the applicable limitation established pursuant to 42 C.F.R. 447.272, 42 C.F.R. 447.321 or as otherwise established by the centers for medicare and medicaid services;

(x) "Upper payment limit gap" means the amount calculated annually by the department constituting the difference between the applicable upper payment limit and medicaid payments made subject to that limit in a fiscal year, excluding any quarterly adjustment payments authorized by this chapter;

(xi) "Hospital services" means inpatient, outpatient and other services provided by a private hospital or by practitioners employed by, under contract with or in affiliation with a hospital-affiliated professional service provider group. Hospital services for purposes of this act include services provided in a psychiatric residential treatment facility owned, operated by or affiliated with a private hospital.

42-9-103. Private hospital assessment account.

(a) The private hospital assessment account is created.

(b) The state treasurer shall invest amounts deposited within the account in accordance with law and all investment earnings shall be credited back to the account. Funds in the account are continuously appropriated to the department for the purposes specified in this section.

(c) The account shall consist of:

(i) Amounts collected or received by the department from private hospital assessments under this chapter;

(ii) All federal matching funds received by the department as a result of expenditures made by the department pursuant to this chapter.

(d) The account shall be used exclusively for the following purposes:

(i) To pay administrative expenses incurred by the department or its agent in performing the activities authorized by this chapter, provided that these expenses shall not exceed a total of three percent (3%) of the aggregate assessment funds collected in the fiscal year;

(ii) To secure federal matching funds available through the state medicaid plan as approved pursuant to W.S. 42-9-108, which shall be used to make quarterly adjustment payments as provided by this chapter;

(iii) To repay to the federal government any excess payments received or made to private hospitals if the state plan, after approval by the centers for medicare and medicaid services, is subsequently disapproved for any reason and after the state has exhausted all appeals. Private hospitals shall

refund any excess payments to the assessment account. If a private hospital is unable to refund payments as provided in this paragraph, the department shall develop a payment plan to recoup deficient payments and accordingly deduct amounts from future medicaid payments. The department shall refund the federal government for the federal portion of those overpayments;

(iv) To refund assessments paid by private hospitals for quarterly adjustment payments which were earned but not paid by the department, but only after the payments authorized by paragraphs (i) and (iii) of this section have been made.

42-9-104. Assessments.

(a) Each private hospital shall pay a private hospital assessment to the department in accordance with this section. Hospitals owned or operated by the state or any city, town, county, special district or other political subdivision of the state or local government shall not be required to pay the assessment required by this section.

(b) The assessment due under this section shall be imposed each fiscal year in an amount calculated as a uniform percentage of each hospital's net patient revenue. The assessment rate shall be determined by the department on a prospective basis and shall be based on the percentage of net hospital patient revenue needed to generate an amount not to exceed the nonfederal portion of the upper payment limit gap plus the fee authorized by W.S. 42-9-103(d) (i). In no event shall the assessment rate:

(i) Exceed the indirect guarantee threshold amount established by 42 C.F.R. 433.68(f) (3) (i) or other federal law;

(ii) Exceed two percent (2%) of a hospital's net patient revenue for the first fiscal year in which the hospital is assessed;

(iii) Increase by more than one percent (1%) of a hospital's net patient revenue for each fiscal year following the first fiscal year in which the hospital is assessed without further approval by the legislature.

(c) Unless otherwise determined by the department, the department shall collect and each private hospital shall pay the assessment required by this section on a quarterly basis, each payment constituting twenty-five percent (25%) of the annual

assessment determined by the department. The initial payment shall be due not later than forty-five (45) days after the state plan has been approved by the centers for medicare and medicaid services unless a later date is set by the department. Subsequent payments are due not later than forty-five (45) days after the end of each calendar quarter unless a later date is set by the department.

(d) If a private hospital ceases to operate as a hospital or for any reason ceases to be subject to the assessment imposed under this chapter, the assessment for the fiscal year in which the cessation occurs shall be adjusted by multiplying the annual assessment by a fraction, the numerator of which is the number of days in the year during which the hospital is subject to the assessment and the denominator of which is three hundred sixty-five (365). Immediately upon ceasing to operate as a hospital, or otherwise ceasing to be subject to this chapter, the hospital shall pay the assessment for each quarter as adjusted, to the extent not previously paid.

42-9-105. Penalties for failure to pay assessment.

(a) If a private hospital fails to pay an assessment due under this chapter, there shall be added to the assessment a penalty equal to five percent (5%) of the amount of the assessment that was not paid when due. The penalty under this section may be waived by the department for good cause. Any payments made after a penalty is assessed under this section shall be credited first to unpaid assessment amounts rather than to penalty amounts, beginning with the most delinquent installment.

(b) In addition to the penalty under subsection (a) of this section, the department may implement any of the following remedies for failure of a private hospital to pay its assessment when due under this chapter:

(i) Withhold any medicaid payments, including any quarterly adjustment payments, until the assessment is paid; or

(ii) Develop a plan that requires the private hospital to pay any delinquent assessment in installments.

42-9-106. Quarterly adjustment payments.

(a) To preserve the quality and improve access to private hospital services, the department shall make quarterly adjustment payments as set forth in this section.

(b) Each private hospital that pays assessments under this chapter and is eligible to receive medicaid payments shall be eligible to receive quarterly adjustment payments as provided in this section. The department shall distribute quarterly adjustment payments in an amount up to but not to exceed the applicable upper payment limit gap. The department shall establish a uniform methodology by which to distribute quarterly adjustment payments in compliance with applicable federal and state medicaid laws and regulations.

(c) Quarterly adjustment payments shall not be used to offset any other payment by medicaid for hospital services to medicaid beneficiaries, including without limitation any fee-for-service, per diem, private hospital inpatient adjustment or cost settlement payment.

(d) No private hospital shall be guaranteed, expressly or otherwise, that any quarterly adjustment payment will equal or exceed the amount of the private hospital assessments due under this chapter.

(e) Monies made available by this chapter shall not be used to replace other general revenues appropriated and funded by the legislature or other revenues used to support medicaid.

42-9-107. Discontinuation of the assessment and quarterly adjustment payments.

(a) The assessment imposed by this chapter shall be discontinued if:

(i) The state plan amendment reflecting the quarterly adjustment payments authorized by this chapter is not approved by the centers for medicare and medicaid services. The department may modify the quarterly adjustment payment provisions as necessary to obtain the centers for medicare and medicaid services approval if the changes do not exceed the authority and purposes of this chapter;

(ii) Federal financial participation to match assessments under this chapter becomes unavailable under federal law. In this event, the department shall terminate the

imposition of assessments beginning on the date the federal statutory, regulatory or interpretive change takes effect.

(b) If collection of the assessment is discontinued as provided in this section, quarterly adjustment payments shall be discontinued and, after payment of all amounts under W.S. 42-9-103(d)(i) and (iii), any assessments remaining in the account shall be returned to the private hospitals from which the assessments were collected on the same basis as they were collected.

42-9-108. Approval of state plan; rulemaking.

(a) The department shall seek necessary federal approval in the form of state plan amendments in order to continue to implement the provisions of this chapter. The department shall be deemed to satisfy this requirement by seeking approval for the operation of an upper payment limit program that provides for quarterly adjustment payments. While seeking federal approval under this subsection, the department may modify payment or qualification provisions as necessary to obtain the Centers for Medicare and Medicaid Services approval if the changes do not exceed the authority and purposes of this chapter.

(b) The department shall adopt rules and regulations necessary to implement the provisions of this chapter and to obtain approval of the state plan amendments.

42-9-109. Multiple facilities.

If a person conducts, operates or maintains more than one (1) private hospital licensed by the department, the person shall pay the assessment for each private hospital separately.

CHAPTER 10 - WELFARE FRAUD PREVENTION ACT

ARTICLE 1 - GENERAL PROVISIONS

42-10-101. Definitions.

(a) As used in this chapter:

(i) "Identity information" includes the name, alias, date of birth, address, social security number and other related information of an applicant for or recipient of a public welfare benefit;

(ii) "Public welfare benefit" means as provided in W.S. 42-2-102(a)(vii).

42-10-102. Enhanced identity authentication process.

Prior to awarding any public welfare benefit the department may require an applicant to complete an identity authentication process that confirms the applicant owns the identity presented in the application. The identity authentication process under this section shall consist of financial or personal questions related to the applicant. The authentication process shall be available for applicant interviews in person or by telephone.

42-10-103. Enhanced eligibility verification process.

(a) Prior to awarding any public welfare benefit, and on a quarterly basis after any benefit is awarded, the department shall, to the extent practicable, determine the following information as it relates to each applicant for or recipient of a public welfare benefit:

Note: Effective 1/1/2027 this subsection will read as:

(a) Prior to awarding any public welfare benefit, and at the intervals specified in this section after any benefit is awarded, the department shall, to the extent practicable, determine the following information as it relates to each applicant for or recipient of a public welfare benefit:

(i) Earned and unearned income information maintained by the United States internal revenue service;

(ii) Weekly, monthly or quarterly reports of income and unemployment insurance payment information maintained by the department of workforce services;

(iii) Income information maintained by the United States social security administration;

Note: Effective 1/1/2027 this paragraph will read as:

(iii) Income information maintained by the United States social security administration, reviewed by the department at every application and recertification period;

(iv) Immigration status information maintained by the United States citizenship and immigration services;

Note: Effective 1/1/2027 this paragraph will read as:

(iv) Immigration status information maintained by the United States citizenship and immigration services and verified through the SAVE online service or other acceptable documentation;

(v) Death register information maintained by the United States social security administration;

Note: Effective 1/1/2027 this paragraph will read as:

(v) Death register information maintained by the United States social security administration, reviewed by the department not less than on a monthly basis;

(vi) Prisoner information maintained by the United States social security administration;

Note: Effective 1/1/2027 this paragraph will read as:

(vi) Prisoner information maintained by the United States social security administration, reviewed by the department of family services at every application and recertification period;

(vii) Public housing and section 8 housing assistance payment information;

Note: Effective 1/1/2027 this paragraph will read as:

(vii) Public housing and section 8 housing assistance payment information, reviewed by the department of family services at every application and recertification period;

(viii) Fleeing felon, probation or parole violation information;

Note: Effective 1/1/2027 this paragraph will read as:

(viii) Fleeing felon, probation or parole violation information, reviewed by the department of family services at every application and recertification period;

(ix) Wage reporting information maintained by states contiguous to Wyoming;

(x) Beneficiary records and earnings information maintained by the United States social security administration in the beneficiary and earnings data exchange system;

Note: Effective 1/1/2027 this paragraph will read as:

(x) Beneficiary records and earnings information maintained by the United States social security administration in the beneficiary and earnings data exchange system, reviewed by the department at every application and recertification period;

(xi) Earnings and pension information maintained by the United States social security administration in the beneficiary earnings exchange record system;

Note: Effective 1/1/2027 this paragraph will read as:

(xi) Earnings and pension information maintained by the United States social security administration in the beneficiary earnings exchange record system, reviewed by the department at every application and recertification period;

(xii) Earnings and pension information maintained by the Wyoming retirement system;

Note: Effective 1/1/2027 this paragraph will read as:

(xii) Earnings and pension information maintained by the Wyoming retirement system, reviewed by the department of family services at every application and recertification period and by the department of health upon the receipt of applicable information from the Wyoming retirement system;

(xiii) Employment information maintained by the department of workforce services;

Note: Effective 1/1/2027 this paragraph will read as:

(xiii) Employment information, reviewed by the department at every application and recertification period;

(xiv) Employment information maintained by the United States department of health and human services in the national directory of new hires;

Note: Effective 1/1/2027 this paragraph will read as:

(xiv) Employment information maintained by the United States department of health and human services in the national directory of new hires, reviewed by the department of family services at every application and recertification period;

(xv) Supplemental security income information maintained by the United States social security administration in the social security income state data exchange system;

Note: Effective 1/1/2027 this paragraph will read as:

(xv) Supplemental security income information maintained by the United States social security administration in the social security income state data exchange system, reviewed by the department at every application and recertification period;

(xvi) Veterans' benefits information;

(xvii) Child care services information maintained by the department;

(xviii) Utility payment information maintained by the state under the low income home energy assistance program as provided in W.S. 42-2-501;

(xix) Emergency utility payment information maintained by the state or local governmental entities; and

(xx) Income and employment information maintained by the department and the United States department of health and human services office of child support enforcement.

(b) The department is authorized to enter into agreements with third-party vendors to obtain the following information prior to awarding any public welfare benefit, and on a quarterly basis after any benefit is awarded:

(i) Information on public welfare benefits received in other states maintained in any real time national database, including the national accuracy clearinghouse;

(ii) A nationwide public records data source of physical asset ownership including real property, automobiles, watercraft, aircraft, luxury vehicles or any other vehicle;

(iii) A nationwide public records data source of incarcerated individuals;

(iv) A nationwide best available address and driver's license data source to verify individuals are residents of Wyoming;

(v) A comprehensive public records database that identifies potential identity fraud or identity theft which can closely associate name, social security number, date of birth, phone and address information; or

(vi) National and local financial institutions, in order to locate undisclosed depository accounts or verify account balances of disclosed accounts.

(c) In addition to the records specified in subsections (a) and (b) of this section, the department may also consider information from any database or source which is substantially similar to or a successor of any record, database or information specified under this section.

*(d) On not less than a quarterly basis, the department of family services and department of health shall each make available on their public websites all of the following data from findings on noncompliance and fraud investigations, provided the data is presented in the aggregate and does not include confidential or personally identifying information:
[NOTE: This subsection will be effective 1/1/2027.]*

(i) The total number of public benefit cases investigated for intentional program violations or fraud;

(ii) The total number of public benefit cases referred to the attorney general's office for prosecution;

(iii) Total improper payments and expenditures;

(iv) Total monies received;

(v) *Aggregate data concerning improper payments and ineligible recipients as a percentage of those recipients investigated and reviewed.*

42-10-104. Case review process.

(a) If the department finds a discrepancy or change in circumstances as a result of the activities required by W.S. 42-10-102 or 42-10-103, the department shall review the case using the following procedures:

(i) If the discrepancy or change in circumstances does not affect eligibility, the department shall take no further action;

(ii) If the discrepancy or change in circumstances may affect eligibility, the department shall:

(A) Promptly make a determination of the effect of the discrepancy or change in circumstances on the eligibility of the applicant or recipient; and

(B) Provide written notice to the applicant or recipient describing in detail the circumstances of the discrepancy or change in circumstances, the manner in which the applicant or recipient may respond and the consequences of failing to take any action. The department shall give the applicant or recipient an opportunity to explain the discrepancy or change in circumstances.

(iii) The applicant or recipient shall respond within ten (10) business days from the date of the written notice of the discrepancy or change in circumstances;

(iv) If an applicant or recipient does not respond to a notice of a discrepancy or change in circumstances as provided in paragraph (ii) of this subsection and the department determines that the discrepancy or change in circumstances affects eligibility for a public welfare benefit, the department shall provide a written decision of the intent to deny, reduce the benefit or close the benefit case;

(v) If an applicant or recipient responds to a notice of a discrepancy or change in circumstances as provided in paragraph (ii) of this subsection, the department shall investigate and make a determination of whether or not the discrepancy or change in circumstances has been resolved and

determine the applicant's or recipient's eligibility for public welfare benefits. The decision of the department shall be provided to the applicant or recipient in writing;

(vi) A written decision of the department under this section shall constitute a final decision of the department subject to judicial review as provided in W.S. 16-3-114.

42-10-105. Referral of cases for investigation.

(a) After review of a discrepancy or change in circumstances under W.S. 42-10-104, if the department finds that there is inadequate documentation or upon reasonable suspicion that there is fraud, misrepresentation, identity theft or another violation of law the department shall:

(i) Refer the case to the fraud and recovery unit for investigation, recovery of improper payments and collection of civil penalties, if applicable and, if appropriate, referral to prosecuting authorities for criminal prosecution;

(ii) Refer the information to other agencies, divisions or departments as appropriate for review of eligibility in public programs.

(b) To the extent the department encounters an individual enrolled in Medicaid who the department has reason to believe is not eligible for Medicaid, the department shall inform the individual and the Wyoming Medicaid program of the reason the department does not believe the individual is eligible.

42-10-106. Report.

Not later than November 30 of 2017, 2018 and 2020 the department shall report to the governor and the joint labor, health and social services interim committee on the effectiveness of the eligibility verification system and the number of cases referred under W.S. 42-10-105 including information on the outcome of the cases, if available, and on the cost to the department of the system.

42-10-107. Rulemaking authority.

The department shall promulgate rules necessary to implement this chapter.

42-10-108. Prohibition on self-attestation. Note: this section is effective as of 1/1/2027.

(a) Except as required under federal law, self-attestation shall not be accepted for any of the following eligibility factors without verification prior to enrollment in the medicaid program:

(i) Income in excess of zero dollars (\$0.00);

(ii) Residency;

(iii) Identity;

(iv) Except for any presumptive eligibility period, citizenship or immigration status.

(b) The department shall not rely on self-attestation to establish any medicaid eligibility factor unless expressly required by federal law.

42-10-109. Residency verification; monthly address checks; multistate enrollment; monthly death record checks. Note: this section is effective as of 1/1/2027.

(a) As used in this section, "address change information" means postal change of address data, state address change databases or comparable systems.

(b) On not less than a monthly basis, the department of health shall review address change information to identify potential changes in residency for medicaid recipients.

(c) The department of health shall conduct monthly cross checks of address change information against enrollment records and shall initiate an eligibility redetermination when a change in residency is indicated.

(d) The department of health shall submit enrollment information to any national database used to identify persons enrolled in medicaid in multiple states. Implementation of this subsection shall occur no later than October 1, 2029.

(e) Not later than August 31 of each year, the department of health shall submit a public report to the joint labor, health and social services interim committee of the Wyoming legislature, including:

(i) The number of persons flagged through address change information or out of state benefit activity;

(ii) The number of persons removed from the medicaid program due to enrollment in multiple states;

(iii) The estimated fiscal impact of this section.

(f) On not less than a monthly basis, the department of health shall receive and review information from the vital statistics services and the social security administration master death file to identify any deceased persons enrolled in the medicaid program. Upon confirmation of death, the department shall promptly remove the deceased person from the program.

42-10-110. Retroactive medicaid eligibility; rulemaking; reporting. Note: this section is effective as of 1/1/2027.

(a) As used in this section:

(i) "Retroactive eligibility" means coverage for services furnished prior to the month of application as authorized by 42 U.S.C. § 1396a(a) (34);

(ii) "Medicaid eligible population" means persons eligible for medicaid under state or federal law.

(b) Retroactive medicaid eligibility shall not extend more than two (2) months prior to the month in which a completed medicaid application is submitted.

(c) This limitation applies only to initial applications and shall not affect ongoing eligibility.

(d) The department of health shall adopt rules necessary to implement this section.

(e) Not later than August 1 of each year, the department of health shall submit a report to the joint labor, health and social services interim committee of the Wyoming legislature, including:

(i) The number of medicaid applications processed;

(ii) The number of applicants denied retroactive eligibility under this section; and

(iii) *The estimated fiscal impact of the limitation.*

(f) *This section shall be implemented not later than January 1, 2027.*

ARTICLE 2 - WAIVER OF WORK REQUIREMENTS

42-10-201. Prohibition on waiver of work requirements and exemptions. Note: this section is effective as of 1/1/2027.

(a) *The department of family services shall not seek, apply for, accept or renew any waiver of work requirements under 7 U.S.C. § 2015(o)(4) without first obtaining specific authorization from the legislature. Such authorization shall be provided in a duly enacted statute.*

(b) *The department of family services shall not exercise the state's option to provide any exemptions from the work requirement under 7 U.S.C. § 2015(o)(6)(F), except for family caregivers as defined in section 2 of the Recognize, Assist, Include, Support and Engage Family Caregivers Act of 2017.*

CHAPTER 11 - PRIVATE GROUND AMBULANCE SERVICE PROVIDER ASSESSMENT ACT

42-11-101. Short title.

This chapter shall be known and may be cited as the "Wyoming Private Ground Ambulance Service Provider Assessment Act."

42-11-102. Definitions.

(a) As used in this chapter:

(i) "Account" means the private ground ambulance service provider assessment account created by W.S. 42-11-103;

(ii) "Ambulance" has the same meaning as defined in W.S. 33-36-102(a)(i)(A) and (B);

(iii) "Department" means the department of health;

(iv) "Fiscal year" means the twelve (12) month period beginning October 1 and ending September 30;

(v) "Private ground ambulance service provider" means any person operating a licensed ambulance service designed to operate on the ground, which is not owned or operated by the state or any city, town, county, special district or other political subdivision of the state or local government;

(vi) "License" and "licensed" means an ambulance business license issued under W.S. 33-36-104 that is not expired and has not been revoked or suspended;

(vii) "Medicaid" means the medical assistance program established by title XIX of the federal Social Security Act and administered in this state by the department pursuant to the Wyoming Medical Assistance and Services Act;

(viii) "Net patient revenue" means all amounts received by a private ground ambulance service provider licensed under W.S. 33-36-104 for the provision of licensed, ground ambulance services in the state of Wyoming. The department shall establish a procedure for determining net patient revenue for purposes of the assessment provided under W.S. 42-11-104;

(ix) "Quarterly adjustment payment" means the quarterly payments made to private ground ambulance service providers that the department may establish and distribute pursuant to W.S. 42-11-106;

(x) "Rate enhancement" means Medicaid reimbursement rate increases to private ground ambulance service providers, as determined by the department and approved by the Centers for Medicare and Medicaid Services;

(xi) "Upper payment limit" means a limitation on aggregate Medicaid payments to private ground ambulance service providers, or another applicable class of Medicaid payees, as established by the Centers for Medicare and Medicaid Services;

(xii) "Upper payment limit gap" means the amount calculated annually by the department constituting the difference between the applicable upper payment limit and Medicaid payments made subject to that limit in a fiscal year, excluding any payments authorized by this chapter.

42-11-103. Private ground ambulance service provider assessment account.

(a) The private ground ambulance service provider assessment account is created.

(b) The state treasurer shall invest amounts deposited in the account in accordance with law and all investment earnings shall be credited back to the account. Funds in the account are continuously appropriated to the department for the purposes specified in this section.

(c) The account shall consist of:

(i) Amounts collected or received by the department from private ground ambulance service provider assessments under this chapter;

(ii) All federal matching funds received by the department as a result of expenditures made by the department pursuant to this chapter.

(d) The account shall be used exclusively for the following purposes:

(i) To pay administrative expenses incurred by the department or its agent in performing the activities authorized by this chapter, provided that these expenses shall not exceed a total of three percent (3%) of the aggregate assessment funds collected in the fiscal year;

(ii) To secure federal matching funds available through the state Medicaid plan as approved pursuant to W.S. 42-11-108, which shall be used to make quarterly adjustment payments or to provide rate enhancements to private ground ambulance service providers as provided by this chapter;

(iii) To repay to the federal government any excess payments received or made to private ground ambulance service providers if the state plan, after approval by the Centers for Medicare and Medicaid Services, is subsequently disapproved for any reason and after the state has exhausted all appeals. Private ground ambulance service providers shall refund any excess payments to the assessment account. If a private ground ambulance service provider is unable to refund payments as provided in this paragraph, the department shall develop a payment plan to recoup deficient payments and accordingly deduct amounts from future Medicaid payments. The department shall refund the federal government for the federal portion of those overpayments;

(iv) To refund assessments paid by private ground ambulance service providers for payments which were earned but not paid by the department, but only after the payments authorized by paragraphs (i) and (iii) of this subsection have been made.

42-11-104. Assessments.

(a) Each private ground ambulance service provider shall pay a private ground ambulance service provider assessment to the department in accordance with this section.

(b) The assessment due under this section shall be imposed each fiscal year in an amount calculated as a uniform percentage of each private ground ambulance service provider's net patient revenue. The assessment rate shall be determined by the department on a prospective basis and shall be based on the percentage of private ground ambulance service provider net patient revenue necessary to generate an amount not to exceed the nonfederal portion of the upper payment limit gap plus the fee authorized by W.S. 42-11-103(d) (i). If a rate enhancement is paid to private ground ambulance service providers pursuant to this chapter, the assessment rate shall include a uniform percentage of each private ground ambulance service provider's net patient revenue necessary to generate the nonfederal portion of all enhanced rates paid under this chapter plus the fee authorized by W.S. 42-11-103(d) (i). In no event shall assessments or the assessment rate exceed the indirect guarantee threshold amount established by 42 C.F.R. 433.68(f) (3) (i) or other federal law.

(c) Unless otherwise determined by the department, the department shall collect and each private ground ambulance service provider shall pay the assessment required by this section on a quarterly basis, each payment constituting twenty-five percent (25%) of the annual assessment determined by the department. The initial payment shall be due not later than forty-five (45) days after the state plan has been approved by the Centers for Medicare and Medicaid Services unless a later date is set by the department. Subsequent payments are due not later than forty-five (45) days after the end of each calendar quarter unless a later date is set by the department.

(d) If a private ground ambulance service provider ceases to operate as an ambulance service or for any reason ceases to be subject to the assessment imposed under this chapter, the

assessment for the fiscal year in which the cessation occurs shall be adjusted by multiplying the annual assessment by a fraction, the numerator of which is the number of days in the year during which the private ground ambulance service provider is subject to the assessment and the denominator of which is three hundred sixty-five (365). Immediately upon ceasing to operate as an ambulance service provider, or otherwise ceasing to be subject to this chapter, the private ground ambulance provider shall pay the assessment for each quarter as adjusted, to the extent not previously paid.

42-11-105. Penalties for failure to pay assessment.

(a) If a private ground ambulance service provider fails to pay an assessment due under this chapter, there shall be added to the assessment a penalty equal to five percent (5%) of the amount of the assessment that was not paid when due. The penalty under this section may be waived by the department for good cause. Any payments made after a penalty is assessed under this section shall be credited first to unpaid assessment amounts rather than to penalty amounts, beginning with the most delinquent installment.

(b) In addition to the penalty under subsection (a) of this section, the department may implement any of the following remedies for failure of a private ground ambulance service provider to pay its assessment when due under this chapter:

(i) Withhold any Medicaid payments, including any quarterly adjustment payments or rate enhancements, until the assessment is paid;

(ii) Develop a plan that requires the private ground ambulance service provider to pay any delinquent assessment in installments;

(iii) Suspend or revoke the private ground ambulance service provider's license.

42-11-106. Payments to private ground ambulance service providers.

(a) Subject to W.S. 42-11-107, the initiation of assessments under W.S. 42-11-104(c) and the federal approval authorized in W.S. 42-11-108, the department shall make quarterly adjustment payments to or implement rate enhancements

for private ground ambulance service providers as set forth in this section.

(b) Each private ground ambulance service provider that pays assessments under this chapter and meets the eligibility standards set by subsection (c) of this section shall be eligible to receive quarterly adjustment payments as provided in this section. The department shall distribute quarterly adjustment payments in amounts up to but not to exceed the applicable upper payment limit gap. The department shall establish a uniform methodology by which to distribute payments in compliance with applicable federal and state Medicaid laws and regulations.

(c) Unless otherwise prohibited by federal law, only private ground ambulance service providers who meet all of the following requirements shall be eligible to receive a quarterly adjustment payment authorized in subsection (b) of this section:

(i) Private ground ambulance service providers who provide ground ambulance services to Medicaid beneficiaries;

(ii) Private ground ambulance service providers who provide ground ambulance services to Medicare beneficiaries;

(iii) Private ground ambulance service providers who accept as full payment for ground ambulance services any payments made under Wyoming's worker's compensation system; and

(iv) Private ground ambulance service providers who:

(A) Are network providers for all insurers offering private health benefit plans in this state who maintain not less than a twenty percent (20%) share of the state's individual or small group health insurance market; or

(B) Have made a bonafide and reasonable offer to become a network provider to all of the insurers identified in subparagraph (A) of this paragraph by offering to accept as network provider reimbursement not more than double the Medicaid reimbursement rate for relevant medical services. The offer required by this subparagraph may be higher to the extent the private ground ambulance service provider demonstrates to the department that the actual cost of providing relevant medical services plus six percent (6%) of the actual cost is an amount higher than double the Medicaid reimbursement rate for the relevant medical services.

(d) To the extent rate enhancements are approved by the Centers for Medicare and Medicaid Services and subject to the collection of assessments under W.S. 42-11-104(b), the department shall provide rate enhancement payments to private ground ambulance service providers consistent with applicable federal and state requirements.

(e) Quarterly payments or rate enhancements shall not be used to offset any other payment by Medicaid for ground ambulance services to Medicaid beneficiaries, including without limitation any fee-for-service, per diem, adjustment or cost settlement payments.

(f) No private ground ambulance service provider is guaranteed, expressly or otherwise, that quarterly adjustment payments or rate enhancements will equal or exceed the amount of private ground ambulance service provider assessments due under this chapter.

(g) Monies made available by this chapter shall not be used to replace other general revenues appropriated and funded by the legislature or other revenues used to support Medicaid.

42-11-107. Discontinuation of the assessment and payments.

(a) The assessments imposed by this chapter shall be discontinued or not allowed if:

(i) The state plan amendment or other agreement with the Centers for Medicare and Medicaid Services reflecting the payments authorized by this chapter is not approved by the Centers for Medicare and Medicaid Services. The department may modify the payment or qualification provisions as necessary to obtain the Centers for Medicare and Medicaid Services approval if the changes do not exceed the authority and purposes of this chapter;

(ii) Federal financial participation to match assessments under this chapter becomes unavailable under federal law. In this event, the department shall terminate the imposition of assessments beginning on the date the federal statutory, regulatory or interpretive change takes effect.

(b) If the collection of assessments is discontinued as provided in this section, payments or rate enhancements under this chapter shall be discontinued and, after payment of all

amounts under W.S. 42-11-103(d) (i) and (iii), any assessments remaining in the account shall be returned to the private ground ambulance service providers from which the assessments were collected on the same basis as they were collected.

(c) If the department is collecting assessments for both quarterly adjustment payments and rate enhancements and both collections are not discontinued, the department shall continue to maintain the account as required by this chapter for the type of assessment that continues to be collected.

42-11-108. Approval of state plan; rulemaking.

(a) The department shall seek necessary federal approval in the form of state plan amendments or otherwise in order to implement the provisions of this chapter. The department shall be deemed to satisfy this requirement by seeking approval for the operation of an upper payment limit program that provides for quarterly adjustment payments, by seeking approval for rate enhancements, or both. While seeking federal approval under this subsection, the department may modify payment or qualification provisions as necessary to obtain the Centers for Medicare and Medicaid Services approval if the changes do not exceed the authority and purposes of this chapter.

(b) The department shall adopt rules and regulations necessary to implement the provisions of this chapter.

42-11-109. Multiple ambulance services.

If a person conducts, operates or maintains more than one (1) private ground ambulance service provider licensed by the department, the person shall pay the assessment for each private ground ambulance service provider separately.

*CHAPTER 12 -CITIZENS AND QUALIFIED ALIENS STATUS VERIFICATION
FOR WELFARE*

42-12-101. Definition of citizens who are eligible for public assistance. Note: this section is effective as of 1/1/2027.

(a) *Unless required by federal law, no person who is not a United States citizen or national of the United States shall be eligible to receive food assistance through the supplemental nutrition assistance program, unless that individual meets the definition of a qualified alien pursuant to 8 U.S.C. § 1641(b).*

(b) No person who is not a United States citizen or national of the United States shall be eligible to receive medical assistance through medicaid, unless that person meets the definition of an eligible alien pursuant to 42 U.S.C. § 1396b(v) and meets the definition of a qualified alien pursuant to 8 U.S.C. § 1641(b).

(c) No person who is not a United States citizen or national of the United States shall be eligible to receive assistance through the personal opportunities with employment responsibilities (POWER) program, unless that person meets the definition of a qualified alien pursuant to 8 U.S.C. § 1641(b).

42-12-102. Verification of citizenship or eligible alien status. Note: this section is effective as of 1/1/2027.

(a) The department of family services shall be required to verify that a person is eligible to participate in the supplemental nutrition assistance program during enrollment and eligibility recertification by verifying citizenship or eligible alien status by using the United States citizenship and immigration services' systematic alien verification for entitlements (SAVE) online service or requiring the person to provide an acceptable form of proof of citizenship or eligible alien status, including but not limited to certified birth certificates, United States passports and United States customs and immigration services documentation.

(b) The department of health shall be required to verify that a person is eligible for medicaid during enrollment and eligibility redetermination by verifying citizenship or eligible alien status using the SAVE online service or requiring the person to provide an acceptable form of proof of citizenship or eligible alien status, including but not limited to, certified birth certificates, United States passports and United States customs and immigration services documentation.

(c) The department of family services or other applicable agency shall be required to verify that a person is eligible for the POWER program during enrollment and eligibility redetermination by verifying citizenship or eligible alien status using the SAVE online service or requiring the person to provide an acceptable form of proof of citizenship or eligible alien status, including but not limited to, certified birth certificates, United States passports and United States customs and immigration services documentation.

(d) The department of family services shall submit to the United States department of agriculture information concerning any assistance unit member for whom it is unable to verify eligible alien status.

(e) The department of health shall submit to the United States department of health and human services information concerning any person member for whom it is unable to verify eligible alien status.

42-12-103. Referral of illegal aliens to law enforcement. Note: this section is effective as of 1/1/2027.

The department of health and department of family services shall submit to the appropriate law enforcement authorities, including but not limited to the United States department of homeland security, information concerning any household member or assistance unit member who it is determined by the applicable department while applying the requirements of this title to be an unlawfully present alien, regardless of whether such household member or assistance unit member is applying to participate in a public assistance program, including but not limited to, the supplemental nutrition assistance program or medicaid.

42-12-104. Counting of ineligible alien income in determination of benefits under the supplemental nutrition assistance program. Note: this section is effective as of 1/1/2027.

The entire income and financial resources of any individual rendered ineligible for participation in the supplemental nutrition assistance program under 7 U.S.C. § 2015(f) shall be considered in determining the eligibility and benefit allotment of the household of which such individual is a member.

42-12-105. Reasonable opportunity periods for noncitizens applying for medicaid. Note: this section is effective as of 1/1/2027.

(a) The department of health shall adhere to the following requirements regarding the reasonable opportunity period for verification of United States citizenship or eligible alien status for medicaid:

(i) When an applicant's status cannot be verified through available data sources, the department shall provide only a single reasonable opportunity period, consistent with the minimum period required under federal law, for the applicant to provide verification;

(ii) Medicaid coverage may only be provided provisionally during the reasonable opportunity period;

(iii) Failure to submit acceptable documentation within the reasonable opportunity period required under federal law shall result in denial or termination of medicaid eligibility, subject to required notice;

(iv) No additional reasonable opportunity period shall be granted to any applicant for medicaid who has previously been denied eligibility at any time due to a failure to verify citizenship or eligible alien status.

42-12-106. Citizenship data collection and presumptive eligibility integrity, medicaid. Note: this section is effective as of 1/1/2027.

(a) The department of health shall require a field for citizenship or eligible alien status on all presumptive eligibility applications. The department shall require hospitals, clinics and other qualified entities authorized to conduct presumptive eligibility determinations to collect and transmit attestations of citizenship or eligible alien status to the department. No presumptive eligibility application shall be approved unless the applicant certifies that they are a United States citizen, United States national, or alien eligible for medicaid pursuant to 42 U.S.C. § 1398b(v) and W.S. 42-12-101(b).

(b) The department of health shall:

(i) Beginning not later than April 1, 2027, require each hospital that accepts medicaid to include a provision on its patient admission or registration form for the patient or the patient's representative to state or indicate whether the patient is a United States citizen or lawfully present in the United States or is not lawfully present in the United States;

(ii) Beginning not later than April 1, 2027, require each hospital that accepts medicaid to inform a patient, at the time this information is collected, that any submission made on

an admission or registration form will not affect patient care, as required by federal law;

(iii) Beginning with the calendar year ending on December 31, 2027 and each calendar year thereafter, require that each hospital shall submit an annual report to the department of health within thirty (30) days after the end of each calendar year which reports the total deidentified number of hospital admissions and emergency department visits within the previous calendar year, disaggregated based on whether the patient or the patient's representative indicated that he or she was or was not a citizen of the United States or lawfully present in the United States or declined to answer together with other information required by the department;

(iv) Beginning on April 1, 2028 and each April 1 thereafter, submit a report to the governor and the joint labor, health and social services interim committee, which includes the number of total deidentified hospital admissions and emergency department visits for the previous calendar year, disaggregated based on whether the patient or patient's representative reported that the patient was or was not a citizen of the United States or lawfully present in the United States or declined to answer. The report shall also describe information relating to the costs of uncompensated care for aliens who are not lawfully present in the United States, the impact of uncompensated care on the cost or ability of hospitals to provide services to the public, hospital funding needs and other related information. The report shall also contain information based on the hospital's presumptive eligibility applications that are submitted to the department by participating providers, including the number of persons determined to be presumptively eligible for medicaid in the prior calendar year, the proportion of the persons presumptively eligible for medicaid who were verified as eligible for medicaid and the proportion of the persons presumptively eligible for medicaid who were determined to be ineligible for medicaid;

(v) Adopt rules relating to the format and information to be contained in quarterly reports and the acceptable formats for hospitals to use in requesting information regarding a patient's immigration status on hospital admission or registration forms.