Health, Department of

Medicaid

Chapter 51: Kid Care Child Health Insurance Program (CHIP)

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CHAPTER 51

Kid Care Child Health Insurance Program (CHIP)

Section 1. Authority. The Wyoming Department of Health (Department) promulgates this Chapter pursuant to the Child Health Insurance Program Act at Wyoming Statutes 35-25-101 through 35-25-108 (The Act).

Section 2. Purpose and Applicability.

(a) The Department adopts this Chapter to govern the Kid Care Child Health Insurance Program ("CHIP") including eligibility, basic level of benefits, and cost-sharing.

(b) This Chapter applies to all applicants and clients for all CHIP services.

(c) The Department may issue manuals and bulletins to interpret this Chapter. Such manuals and bulletins shall be consistent with and reflect this Chapter. The provisions contained in manuals and newsletters shall be subordinate to this Chapter.

Section 3. Definitions.

(a) Except as otherwise specified in Wyoming Medicaid Rules Chapter 1, the terminology used in this Chapter is the standard terminology and has the standard meaning used in health care, health insurance, Medicare, and Medicaid. For the purposes of this Chapter, the following shall apply:

(i) "Benefit year" means a year of benefits coverage that begins January 1 of each year and ends December 31 of the same year.

(ii) "Federal funds" means the Federal funds received by the Department pursuant to 42 C.F.R. § 457 Subpart F.

(iii) "Targeted low income child" means a child who has a household income, as determined according to 42 CFR §457.315, at or below 200 percent of the Federal poverty level for a family of the applicable size.

Section 4. Application Process, Applicant Rights and Responsibilities.

(a) Application Process.

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

(ii) The Department shall act upon an application within forty-five (45) days from the date the application was submitted.

(iii) The Department shall notify the applicant in writing of its application determination along with the reasons and regulations supporting its decision.

(iv) If the application is denied or not acted upon by the Department within forty-five (45) days, the applicant may request an administrative hearing in accordance with Medicaid Rules Chapter 4.

(b) Applicant Rights.

(i) An applicant shall be allowed the opportunity to apply for CHIP without delay.

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

(iii) An applicant may request assistance from the Department in completing the application or obtaining required verification.

(iv) The Department shall inform applicants of the following information:

(A) The eligibility requirements;

(B) Available CHIP services; and

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

(v) Applications and other personal identifying information are confidential and shall not be disclosed, except as allowed by state and federal law.

(vi) An applicant shall not be excluded, denied benefits, or otherwise discriminated against on the grounds of race, color, sex, religion, political belief, national origin, age, or disability.

(c) Applicant Responsibilities.

(i) Applicants shall cooperate in the process of determining eligibility by providing all information and documentation requested by the Department,

(ii) Applicants shall assign to the Department any right to medical support and to payment for medical care from a third party to the extent that CHIP has paid for medical services.

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

(d) Eligibility Period and Redeterminations.

(i) Effective Date of Benefits.

(A) CHIP eligibility begins the first day of the month in which the application was submitted.

(B) Enrolled clients are deemed to be continuously eligible for twelve (12) months from the effective date of eligibility, or for twelve (12) months from the last redermination unless the covered child turns age nineteen (19), enters a public institution, moves out of state, becomes eligible for Medicaid, or requests to be disenrolled.

(ii) The Department shall re-determine a client's eligibility every 12 months.

Section 5. General Eligibility Requirements.

(a) Applicants shall meet the following requirements to be eligible for Medicaid:

(i) Applicants shall be citizens or qualified non-citizens of the United States, and provide documentation of such;

(ii) Applicants shall provide proof of identity;

(iii) Applicants shall reside in Wyoming; and

(iv) Applicants who are citizens or nationals of the United States shall provide record of a social security number.

Section 6. CHIP Eligibility Requirements.

(a) Applicants shall meet the following additional requirements to be eligible for CHIP:

(i) Children must be between the ages of zero (0) and eighteen (18);

(ii) Countable family income shall be between one hundred thirty-four percent (134%) and two hundred percent (200%) of the Federal Poverty Level (FPL) and calculated using the modified adjusted gross income of the household;

(iii) Applicants cannot reside in a public institution;

(iv) Applicants cannot be covered by any health insurance plan, including the State of Wyoming employee health insurance group plan; and

(v) Applicants cannot have been covered by a health insurance plan for a

minimum period of one (1) month before the date of application. The minimum period can be waived when allowable exceptions exist, including the applicant's out-of-pocket health insurance premium costs.

(vi) Applicants and enrolled clients shall immediately report any changes in any of the following circumstances to the Department:

(A) Income;

(B) Household composition;

(C) Health insurance; and

(D) Address.

Section 7. Basic Level of Benefits.

(a) The covered services provided to CHIP clients, at a minimum, shall include the following services:

(i) Inpatient hospital services;

(ii) Outpatient hospital services;

(iii) Physician services;

(iv) Surgical services;

(v) Clinic services and other ambulatory health care services;

(vi) Prescription drugs;

(vii) Laboratory and radiological services;

(viii) Prenatal care and pre-pregnancy family planning services and supplies;

(ix) Inpatient mental health services;

(x) Outpatient mental health services;

(xi) Durable medical equipment, prosthetics and orthotics;

(xii) Abortion, only if necessary to save the life of the mother or if the pregnancy is the result of rape or incest;

(xiii) Dental services;

(xiv) Medically necessary orthodontia;

(xv) Inpatient substance abuse treatment services;

(xvi) Outpatient substance abuse treatment services;

(xvii) Preventive care, screening and immunization;

(xviii) Hospice care;

(xix) Emergency medical transportation where care is administered during transportation;

(xx) Vision services;

(xxi) Dietician services;

(xxii) Hearing services;

(xxiii) Home health services;

(xxiv) Interpretation services;

(xxv) Nurse practitioner and nurse midwife services;

(xxvi) Organ transplant services;

(xxvii) Occupational, physical and speech therapy services;

(xxviii) Rehabilitation services;

(xxix) Non-emergency medical transportation services; and

(xxx) Any other services determined to be medically necessary as defined in Medicaid Rules Chapter 1.

(b) No exclusion for pre-existing conditions or a maximum life-time benefit per client shall be imposed under CHIP.

Section 8. Denial, Termination, Reduction, or Suspension of Eligibility or Services. An applicant or enrolled client who is denied or terminated from eligibility, or whose services are reduced or suspended shall be notified by the Department in writing, and may request an administrative hearing in accordance with Medicaid Rules Chapter 4.

Section 9. Cost Sharing Maximums

(a) Cost sharing shall not exceed five percent (5%) of a family's gross household income for the length of the client's eligibility period. Each family shall be notified of their cost sharing maximum for the eligibility period.

(b) Clients may request Department review of cost sharing totals if they believe their maximum has been reached.

(c) If the Department determines the family has paid more than their five percent (5%) annual cost sharing maximum the family shall be reimbursed for the excess.

Section 10. Co-payments.

(a) The Department shall determine the benefit year for cost sharing co-payments for particular services. Co-payment amounts shall be determined according to the family income reported at the time of application.

(b) Clients who are American Indians or Alaskan Natives as defined in 42 CFR 457.10 shall not have any cost sharing co-payments imposed.

(c) The Department shall include the benefit year maximum amounts for co-payments in the Client Handbook which shall be made available to each CHIP client.

(d) The Department shall not impose co-payments, coinsurance, deductibles or any other cost sharing for well-baby or well-child services, including but not limited to, immunizations and preventive services.

(e) The Department shall not terminate a client because of the failure to make co-payments.

Section 11. Provider Participation. No person or entity that provides services to a client shall receive CHIP funds unless the person or entity is a Medicaid enrolled provider pursuant to Medicaid Rules Chapter 3.

Section 12. Availability of Funding.

(a) If Department projections indicate expenditures may exceed the federal and state funds available under the Act, the Department may limit participation in the CHIP program as follows:

(i) The Department may impose a partial or total moratorium on new CHIP enrollments until funds are available to meet the needs of new clients;

(ii) For existing clients, the Department shall give priority for available

funding to those families with the lowest incomes.

(b) A CHIP program reduction or termination, or the denial or termination of client eligibility or services because of a moratorium or prioritization, is not an adverse action, and shall not be subject to the administrative hearing process of Medicaid Rules Chapter 4.