Health, Department of

Medicaid

Chapter 18: Medicaid Eligibility

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CHAPTER 18

MEDICAID ELIGIBLITY

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

Section 2. Purpose and Applicability.

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

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

Section 3. Definitions.

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

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

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

Section 4. Application Process, Applicant Rights and Responsibilities.

(a) Application Process.

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

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

(A) Aged, Blind and Disabled programs:

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

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

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

(B) Family and Children's programs:

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

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

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

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

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

(b) Applicant Rights.

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

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

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

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

(A) The eligibility requirements;

(B) Available Medicaid services; and

(C) The rights and responsibilities of individuals.

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

(c) Applicant Responsibilities.

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

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

(d) Eligibility Period and Redeterminations.

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

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

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

Section 5. General Eligibility Requirements

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

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

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

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

Section 6. Family and Children's Eligibility.

(a) The following individuals are eligible for Medicaid:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Income;

(ii) Household composition;

(iii) Health insurance; and

(iv) Address.

Section 7. Presumptive Eligibility.

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

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

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

(b) Presumptive Eligibility determinations may be conducted by:

(i) Qualified provider, or

(ii) Qualified Hospital.

(c) Presumptive Eligibility shall be limited to:

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

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

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

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

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

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

Section 8. Aged, Blind or Disabled Eligibility.

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

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

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

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

(b) The following individuals are eligible for Medicaid:

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

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

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

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

(c) Treatment of Income.

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

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

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

(A) Irrevocable.

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

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

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

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

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

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

(d) Treatment of Resources.

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

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

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

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

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

(vi) Treatment of Trusts.

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

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

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

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

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

(IV) Distributions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) Personal Care Contracts

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

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

(A) The date the care begins;

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

(C) How often services will be provided;

(D) How much the caregiver will be compensated;

(E) When the caregiver will be compensated;

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

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

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

(I) The notarized signature of both parties.

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

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

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

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

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

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

(f) Patient Contribution.

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

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

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

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

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

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

(g) Benefits begin:

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

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

(h) Transfer penalties:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Income;

(ii) Resources;

(iii) Household size;

(iv) Health insurance; and

(v) Address.

Section 9. Breast and Cervical Cancer Treatment Program.

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

(b) Eligibility Requirements.

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

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

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

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

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

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

(i) Income;

(ii) Health insurance;

(iii) Address; and

(iv) Conclusion of treatment

Section 10. Employed Individuals with Disabilities Eligibility Group.

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

(b) Eligibility Requirements.

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

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

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

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

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

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

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

(i) Income;

(ii) Household size;

(iii) Health insurance;

(iv) Address; and

(v) Employment.

Section 11. Medicare Savings Programs.

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

(i) Entitled to Medicare.

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

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

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

(i) Entitled to Medicare.

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

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

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

(i) Entitled to Medicare.

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

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

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

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

(i) Income;

(ii) Resources;

(iii) Household size;

(iv) Health insurance; and

(v) Address.

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

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