

Don: HCFA-PM-91-  
1991

(BPD)

ATTACHMENT 2.2-A  
Page 2  
OMB NO.: 0938-

State: WYOMING

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

2. Deemed Recipients of AFDC.

1902(a)(10)(A)(i)(I)  
of the Act

b. ~~Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e)(6) of the Act.~~

406(h)(22)(A)  
of the Act

c. ~~Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.~~

406(h) and  
1902(a)(10)(A)  
(i)(I) of the Act

d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.

1902(a) of  
the Act

e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

\*Agency that determines eligibility for coverage.

TN No. 92-02

Approval Date 3/2/92

Effective Date  
12/1/91

sedes  
TN No. 91-14

HCFA ID: 7983E

Approval on 6/12/14

sion: HCFA-PM-91-  
1991

(BPD)

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Page 2a

OMB NO.: 0938-

State: WYOMING

Agency*	Citation(s)	Groups Covered
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**A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)**

407(b), 1902

~~(a)(10)(A)(i)~~  
and 1905(m)(1)  
of the Act

**3. Qualified Family Members**

Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under section 407 of the Act because the principal wage earner is unemployed.

☐ Qualified family members are not included because cash assistance payments may be made to families with unemployed parents for 12 months per calendar year.

(a)(52)  
and 1925 of  
the Act

4. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)

\*Agency that determines eligibility for coverage.

TN No. 9-14Approval Date 12/19/91

Effective Date

12/1/91

sedes

o. 8-10-90-12

HCFA ID: 7983E

Revision: HCFA-PM-92 -1 (MB)  
FEBRUARY 1992

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WYOMING

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)

Groups Covered

A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

1902(a)(10)  
(A)(i)(V) and  
1905(m) of the  
Act

10. Individuals ~~other than qualified pregnant women~~  
and children ~~above who are~~  
members of ~~be receiving~~  
AFDC under ~~Act if the State~~  
had not ex ~~under section~~  
407(b)(2)(B) ~~limit the number of~~  
months for which a family may receive AFDC.

1902(e)(5)  
of the Act

11. a. A woman who, while pregnant, was eligible  
for, applied for, and receives Medicaid under  
the approved State plan on the day her  
pregnancy ends. The woman continues to be  
eligible, as though she were pregnant, for  
all pregnancy-related and postpartum medical  
assistance under the plan for a 60-day period  
(beginning on the last day of her pregnancy)  
and for any remaining days in the month in  
which the 60th day falls.

1902(e)(6)  
of the Act

- b. A pregnant woman who would otherwise lose  
eligibility because of an increase in income  
(of the family in which she is a member)  
during the pregnancy or the postpartum period  
which extends through the end of the month in  
which the 60-day period (beginning on the  
last day of pregnancy) ends.

TN No. 92-03  
Supersedes  
TN No. 91-14

Approval Date

4/16/92

Effective Date

1/1/92

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WYOMING

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)

Groups Covered

A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

1902(e)(4)  
of the Act

12. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother.

42 CFR 435.120

13. Aged, Blind and Disabled Individuals Receiving Cash Assistance

X a. Individuals receiving SSI.

This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act.

X Aged  
X Blind  
X Disabled

TN No. 92-03

Supersedes

TN No. 91-14

Approval Date

4/16/92

Effective Date

1/1/92

Revision: HCFA-PM-91- (BPD)  
1991

ATTACHMENT 2.2-A  
Page 6a  
OMB NO.: 0938-

State: WYOMING

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Agency*	Citation(s)	Groups Covered
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**A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)**

435.121

1619(b)(1)  
of the Act

13. ☒ b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.)

☐ Aged  
☐ Blind  
☐ Disabled

The more restrictive categorical eligibility criteria are described below:

(Financial criteria are described in  
ATTACHMENT 2.6-A).

\*Agency that determines eligibility for coverage.

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TN No. <u>91-14</u>	Approval Date <u>12/19/91</u>	Effective Date <u>12/1/91</u>
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sedes  
No. 87-5

HCFA ID: 7983E

sion: HCFA-PM-91-  
1991

(BPD)

ATTACHMENT 2.2-A  
Page 6b  
OMB NO.: 0938-

State: WYOMING

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

1902(a)  
(10)(A)  
(i)(II)  
and 1905  
(q) of  
the Act

14. Qualified severely impaired blind and disabled individuals under age 65, who--
- a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or
  - b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must--
    - (1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;
    - (2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;
    - (3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

\*Agency that determines eligibility for coverage.

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TN No. <u>91-14</u>	Approval Date <u>12/19/91</u>	Effective Date <u>12/1/91</u>
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ersedes  
No. 87-5

HCFA ID: 7983E

Revision: HCFA-PM-91- (BPD)  
1991

ATTACHMENT 2.2-A  
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State: WYOMING

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

- (4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and
- (5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.
- ☒ Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

\*Agency that determines eligibility for coverage.

TN No. 91-14 Approval Date 12/19/91 Effective Date 12/1/91

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No. 87-5

HCFA ID: 7983E

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1991

ATTACHMENT 2.2-A  
Page 6d  
OMB NO.: 0938-

State: WYOMING

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

1619(b) (3)  
of the Act

The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b) (1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b) (1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b) (1) of the Act.

\*Agency that determines eligibility for coverage.

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TN No. <u>01-14</u>	Approval Date <u>12/19/91</u>	Effective Date <u>12/1/91</u>
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ersedes  
No. 87-5

HCFA ID: 7983E



State: WYOMING

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

1634(c) of  
the Act

15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who--
- a. Are at least 18 years of age;
  - b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.
  - ☐ c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically
  - ☐ d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy

needy eligibility.

42 CFR 435.122

16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act.

42 CFR 435.130

17. Individuals receiving mandatory State supplements.

\*Agency that determines eligibility for coverage.

TN No. 91-14 Approval Date 12/19/91 Effective Date 12/1/91

ersedes  
No. 87-5

HCFA ID: 7983E

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State: WYOMING

Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

42 CFR 435.131	18.	Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.
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☒ In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

☒ Aged      ☒ Blind      ☒ Disabled

☐ Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

\*Agency that determines eligibility for coverage.

TN No. 91-14      Approval Date 12/19/91      Effective Date 12/1/91

sedes 87-5  
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1991

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ATTACHMENT 2.2-A  
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State: WYOMING

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

- |                |     |  |
|----------------|-----|--|
| 42 CFR 435.132 | 19. | Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they--<br><br>a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and<br><br>b. Remain institutionalized; and<br><br>c. Continue to need institutional care. |
| 42 CFR 435.133 | 20. | Blind and disabled individuals who--<br><br>a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and<br><br>b. Were eligible for Medicaid in December 1973 as blind or disabled; and<br><br>c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.   |

\*Agency that determines eligibility for coverage.

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TN No. <u>91-14</u>	Approval Date <u>12/19/91</u>	Effective Date <u>12/1/91</u>
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ersedes 87-5  
o. 87-5

HCFA ID: 7983E

Revision: HCFA-PM-91-  
1991

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ATTACHMENT 2.2-A

Page 7

OMB NO.: 0938-

State: WYOMING

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

42 CFR 435.134 21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

☐ Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

☒ Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

☐ Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

\*Agency that determines eligibility for coverage.

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TN No. <u>91-14</u>	Approval Date <u>12/19/91</u>	Effective Date <u>12/1/91</u>
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ersedes  
No. 87-5

HCFA ID: 7983E

sion: HCFA-PM-91-  
1991

(BPD)

ATTACHMENT 2.2-A  
Page 8  
OMB NO.: 0938-

State: WYOMING

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Agency*	Citation(s)	Groups Covered
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**A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)**

42 CFR 435.135 22. Individuals who --

- a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and
- b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

☒ Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.

☐ Not applicable because the State applies more restrictive eligibility requirements than those under SSI.

☐ The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

\*Agency that determines eligibility for coverage.

TN No. 91-14

Approval Date 12/19/91

Effective Date 12/1/91

ersedes

o. 87-5

HCFA ID: 7983E

sion: HCFA-PM-91-  
1991

(BPD)

ATTACHMENT 2.2-A  
Page 9  
OMB NO.: 0938-

State: WYOMING

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Agency*	Citation(s)	Groups Covered
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A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

1634 of the  
Act

23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.

☒ Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.

☐ The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equalling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

\*Agency that determines eligibility for coverage.

TN No. 91-14

Approval Date 12/19/91

Effective Date

12/1/91

ersedes 86-687-5  
no.           

HCFA ID: 7983E

State/Territory: WYOMING

Agency\*      Citation(s)      Groups Covered

1634(d) of the  
Act

A. Mandatory Coverage - Categorically Needy and Other  
Required Special Groups (Continued)

24. Disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A.

— The State applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.

— In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in § 1634(d)(1)(A) in determining the income of the individual, but does not disregard any more of this income than would reduce the individual's income to the SSI income standard.

— In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in § 1634(d)(1)(A) in determining the income of the individual, which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to be disregarded is specified in Supplement 4 to Attachment 2.6-A.

— In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in § 1634(d)(1)(A) in determining the income of the individual.

\*Agency that determines eligibility for coverage.

TN No. 92-01  
Supersedes  
TN No. 91-14

Approval Date 2/6/92

Effective Date 1/1/92

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
1600 Broadway, Suite 700  
Denver, CO 80202-4967



## Region VIII

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June 29, 2010

Teri Green, Medicaid Director  
Wyoming Division of Health Care Financing  
401 Hathaway Building  
Cheyenne, WY 82002

RE: Wyoming #10-002

Dear Ms. Green:

We are pleased to inform you that CMS has approved Wyoming State Plan Amendment (SPA) 10-002, "Income and Resources for the Medicare Savings Program" with an effective date of January 1, 2010.

We appreciate the cooperation extended by your staff in the review and approval of this state plan amendment.

If you have any questions concerning this amendment, please contact Cindy Riddle at (303) 844-7116.

Sincerely,

/s/

Richard C. Allen  
Associate Regional Administrator  
Division for Medicaid & Children's Health Operations

CC: Yvonne Stayer  
Lee Clabots, Deputy Director



DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
1600 Broadway, Suite 700  
Denver, CO 80202-4967



**Region VIII**

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**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER:  
10-002

2. STATE  
WYOMING

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE  
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE  
January 1, 2010

5. TYPE OF PLAN MATERIAL (*Check One*):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:  
Section 1902(a)(10)(E)(i)-(iv), 1860D-14(a)(3), 1902(r)(2), and 1905(p)  
of the Act.

7. FEDERAL BUDGET IMPACT: Impact unknown due to  
Legislation.

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 2.2-A, page 9b  
Attachment 2.2-A, page 9c  
Attachment 2.2-A, page 9d  
Attachment 2.2-A, page 9e

Attachment 2.6-A, page 22  
Attachment 2.6-A, page 22a  
Supplemental 8a to Attachment 2.6A, page 1  
Supplemental 8b to Attachment 2.6A, page 4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (*If Applicable*):

Attachment 2.2-A, page 9b  
Attachment 2.2-A, page 9b1  
Attachment 2.2-A, page 9b2  
Attachment 2.2-A, page 9c

Attachment 2.6-A, page 22  
Attachment 2.6-A, page 22a  
Supplemental 8a to Attachment 2.6A, page 1  
New

10. SUBJECT OF AMENDMENT:

Income and Resources for the Medicare Savings programs.

11. GOVERNOR'S REVIEW (*Check One*):

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT  
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED: Delegated to Teri  
Green, State Medicaid Agent, Office of  
HealthCare Financing

12. SIGNATURE OF STATE  
AGENCY OFFICIAL:

13. TYPED NAME: TERI GREEN

14. TITLE: STATE MEDICAID AGENT

15. DATE SUBMITTED: May 20, 2010

16. RETURN TO:

TERI GREEN  
STATE MEDICAID AGENT  
OFFICE OF HEALTH CARE FINANCING  
6101 YELLOWSTONE ROAD, SUITE 210  
CHEYENNE, WY 82002

CC: YVONNE STAYER, MANAGEMENT ASSISTANT  
(SAME ADDRESS)

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:  
03/31/10 Original 05/20/10 Revised

18. DATE APPROVED: June 29, 2010

19. EFFECTIVE DATE OF APPROVED MATERIAL:  
January 1, 2010

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:  
Richard C. Allen

22. TITLE:  
Associate Regional Administrator

23. REMARKS:

State: Wyoming

Agency	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u>
1902(a)(10)(E)(i), 1905(p)		25. Qualified Medicare Beneficiaries -- <ul style="list-style-type: none"> <li>a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act);</li> <li>b. Whose income does not exceed 100 percent of the Federal poverty level; and</li> <li>c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.</li> </ul> <p>(Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)</p>
1902(a)(10)(E)(ii), 1905(p)(3)(A)(i), 1905(p)		26. Qualified Disabled and Working Individuals -- <ul style="list-style-type: none"> <li>a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act;</li> <li>b. Whose income does not exceed 200 percent of the Federal poverty level; and</li> <li>c. Whose resources do not exceed two times the SSI resource limit.</li> <li>d. Who are not otherwise eligible for medical assistance under Title XIX of the Act.</li> </ul> <p>(Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)</p>

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
1600 Broadway, Suite 700  
Denver, CO 80202-4967



**Region VIII**

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June 29, 2010

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401 Hathaway Building  
Cheyenne, WY 82002

RE: Wyoming #10-002

Dear Ms. Green:

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We appreciate the cooperation extended by your staff in the review and approval of this state plan amendment.

If you have any questions concerning this amendment, please contact Cindy Riddle at (303) 844-7116.

Sincerely,

/s/

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**Region VIII**

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**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER:  
10-002

2. STATE  
WYOMING

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE  
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE  
January 1, 2010

5. TYPE OF PLAN MATERIAL (*Check One*):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:  
Section 1902(a)(10)(E)(i)-(iv), 1860D-14(a)(3), 1902(r)(2), and 1905(p)  
of the Act.

7. FEDERAL BUDGET IMPACT: Impact unknown due to  
Legislation.

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 2.2-A, page 9b  
Attachment 2.2-A, page 9c  
Attachment 2.2-A, page 9d  
Attachment 2.2-A, page 9e

Attachment 2.6-A, page 22  
Attachment 2.6-A, page 22a  
Supplemental 8a to Attachment 2.6A, page 1  
Supplemental 8b to Attachment 2.6A, page 4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (*If Applicable*):

Attachment 2.2-A, page 9b  
Attachment 2.2-A, page 9b1  
Attachment 2.2-A, page 9b2  
Attachment 2.2-A, page 9c

Attachment 2.6-A, page 22  
Attachment 2.6-A, page 22a  
Supplemental 8a to Attachment 2.6A, page 1  
New

10. SUBJECT OF AMENDMENT:

Income and Resources for the Medicare Savings programs.

11. GOVERNOR'S REVIEW (*Check One*):

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT  
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED: Delegated to Teri  
Green, State Medicaid Agent, Office of  
HealthCare Financing

12. SIGNATURE OF STATE  
AGENCY OFFICIAL:

13. TYPED NAME: TERI GREEN

14. TITLE: STATE MEDICAID AGENT

15. DATE SUBMITTED: May 20, 2010

16. RETURN TO:

TERI GREEN  
STATE MEDICAID AGENT  
OFFICE OF HEALTH CARE FINANCING  
6101 YELLOWSTONE ROAD, SUITE 210  
CHEYENNE, WY 82002

CC: YVONNE STAYER, MANAGEMENT ASSISTANT  
(SAME ADDRESS)

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:  
03/31/10 Original 05/20/10 Revised

18. DATE APPROVED: June 29, 2010

19. EFFECTIVE DATE OF APPROVED MATERIAL:  
January 1, 2010

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:  
Richard C. Allen

22. TITLE:  
Associate Regional Administrator

23. REMARKS:

Revision:

13-0008-MM1 Supersededes for Caretaker  
Relatives and Pregnant Women  
Approval on 6/12/14

ATTACHMENT 2.2-A  
Page 9e

State: Wyoming

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy

42 CFR  
435.210  
1902 (a)  
(10)(A)(ii) and  
1905(a) of  
the Act

☐ 1. Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional state supplement as specified in 42 CFR 435.230, but who do not receive cash assistance.

☐ The plan covers all individuals as described above.

☐ The plan covers only the following group or groups of individuals:

- ☐ Aged
- ☐ Blind
- ☐ Disabled
- ☐ ~~Caretaker relatives~~
- ☐ ~~Pregnant women~~

42 CFR.  
435.211

☒ 2. Individuals who would be eligible for AFDC, SSI or an optional state supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

\*Agency that determines eligibility for coverage.

TN No: 10-002

Supersedes

TN No. 91-14

Approval Date 6/24/10

Effective Date January 1, 2010

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
1600 Broadway, Suite 700  
Denver, CO 80202-4967



**Region VIII**

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June 29, 2010

Teri Green, Medicaid Director  
Wyoming Division of Health Care Financing  
401 Hathaway Building  
Cheyenne, WY 82002

RE: Wyoming #10-002

Dear Ms. Green:

We are pleased to inform you that CMS has approved Wyoming State Plan Amendment (SPA) 10-002, "Income and Resources for the Medicare Savings Program" with an effective date of January 1, 2010.

We appreciate the cooperation extended by your staff in the review and approval of this state plan amendment.

If you have any questions concerning this amendment, please contact Cindy Riddle at (303) 844-7116.

Sincerely,

/s/

Richard C. Allen  
Associate Regional Administrator  
Division for Medicaid & Children's Health Operations

CC: Yvonne Stayer  
Lee Clabots, Deputy Director



DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
1600 Broadway, Suite 700  
Denver, CO 80202-4967



## Region VIII

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**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER:  
10-002

2. STATE  
WYOMING

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE  
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE  
January 1, 2010

5. TYPE OF PLAN MATERIAL (*Check One*):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:  
Section 1902(a)(10)(E)(i)-(iv), 1860D-14(a)(3), 1902(r)(2), and 1905(p)  
of the Act.

7. FEDERAL BUDGET IMPACT: Impact unknown due to  
Legislation.

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 2.2-A, page 9b  
Attachment 2.2-A, page 9c  
Attachment 2.2-A, page 9d  
Attachment 2.2-A, page 9e

Attachment 2.6-A, page 22  
Attachment 2.6-A, page 22a  
Supplemental 8a to Attachment 2.6A, page 1  
Supplemental 8b to Attachment 2.6A, page 4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (*If Applicable*):

Attachment 2.2-A, page 9b  
Attachment 2.2-A, page 9b1  
Attachment 2.2-A, page 9b2  
Attachment 2.2-A, page 9c

Attachment 2.6-A, page 22  
Attachment 2.6-A, page 22a  
Supplemental 8a to Attachment 2.6A, page 1  
New

10. SUBJECT OF AMENDMENT:

Income and Resources for the Medicare Savings programs.

11. GOVERNOR'S REVIEW (*Check One*):

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT  
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED: Delegated to Teri  
Green, State Medicaid Agent, Office of  
HealthCare Financing

12. SIGNATURE OF STATE  
AGENCY OFFICIAL:

13. TYPED NAME: TERI GREEN

14. TITLE: STATE MEDICAID AGENT

15. DATE SUBMITTED: May 20, 2010

16. RETURN TO:

TERI GREEN  
STATE MEDICAID AGENT  
OFFICE OF HEALTH CARE FINANCING  
6101 YELLOWSTONE ROAD, SUITE 210  
CHEYENNE, WY 82002

CC: YVONNE STAYER, MANAGEMENT ASSISTANT  
(SAME ADDRESS)

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:  
03/31/10 Original 05/20/10 Revised

18. DATE APPROVED: June 29, 2010

19. EFFECTIVE DATE OF APPROVED MATERIAL:  
January 1, 2010

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:  
Richard C. Allen

22. TITLE:  
Associate Regional Administrator

23. REMARKS:

State: Wyoming

Agency	Citation(s)	Groups Covered
		A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</u>
	1902(a)(10)(E)(iii), 1905(p)(3)(A)(ii), and 1860D-14(a)(3)(D) of the Act	<p>27. Specified Low-Income Medicare Beneficiaries --</p> <ul style="list-style-type: none"> <li>a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);</li> <li>b. Whose income is greater than 100 percent but less than 120 percent of the Federal Poverty Level; and</li> <li>c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.</li> </ul> <p>(Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)</p>
	1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii) and 1860D-14(a)(3)(D) of the Act	<p>28. Qualifying Individuals --</p> <ul style="list-style-type: none"> <li>a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);</li> <li>b. Whose income is at least 120 percent but less than 135 percent of the Federal poverty level;</li> <li>c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.</li> </ul>

State: Wyoming

Agency	Citation(s)	Groups Covered
	A. <u>Mandatory Coverage - Categorically Needy and Other Required Special Groups</u> (Continued)	
1634 (e)	29.	<p>a. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (I) or (v) of Section 1611 (e) (3) (A) shall be treated, for purposes of Title XIX, as receiving SSI benefits for the month.</p> <p>_____ b. The state applies more restrictive eligibility standards than those under SSI.</p> <p>Individuals whose eligibility for SSI benefits are based solely on disability who are not payable for any months solely by reason of clause (I) or (v) of Section 1611 (e) (3) (A) and who continue to meet the more restrictive requirements for Medicaid eligibility under the State Plan, are eligible for Medicaid as categorically needy.</p>

State/Territory: WYOMING

Agency*	Citation(s)	Groups Covered
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**B. Optional Groups Other Than the Medically Needy**  
(Continued)

42 CFR 435.212 &  
1902(e)(2) of the  
Act, P.L. 99-272  
(section 9517) P.L.  
101-508 (section  
4732)

3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act or while enrolled in an entity described in section 1903(m)(2)(B)(111), (E) or (G) of the Act, or a Competitive Medical Plan (CMP) with a Medicare contract under section 1876 of the Act, but who have been enrolled in the HMO or entity for less than the minimum enrollment period listed below. The HMO or entity must have a risk contract as specified in 42 CFR 434.20(a). Coverage under this section is limited to HMO services and family planning services described in section 1905(a)(4)(C).

— The State elects not to guarantee eligibility.

— The State elects to guarantee eligibility. The minimum enrollment period is \_\_\_\_\_ months (not to exceed six).

The State measures the minimum enrollment period from:

— The date beginning the period of enrollment in the HMO or other entity, without any intervening disenrollment, regardless of Medicaid eligibility.

— The date beginning the period of enrollment in the HMO as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

— The date beginning the last period of enrollment in the HMO as a Medicaid patient (not including periods when payment is made under this section), without any intervening disenrollment of periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section.)

\*Agency that determines eligibility for coverage.

TN No. 92-01 Approval Date 2/6/92 Effective Date 1/1/92  
Supersedes  
TN No. 91-14


HCFA ID: 7983E

State/Territory: WYOMING

Agency*	Citation(s)	Groups Covered
		<b>B. <u>Optional Groups Other Than the Medically Needy</u></b> <b>(Continued)</b>
1903(m)(2)(F) of the Act, P.L. 98-369 (section 2364), P.L. 99-272 (section 9517), P.L. 101-508 (section 4732)		<p>The Medicaid Agency may elect to restrict the disenrollment rights of Medicaid enrollees of certain Federally qualified HMOs, Competitive Medical Plans (CMPs) with Medicare contracts under section 1876 of the Act, and other organizations described in 42 CFR 434.27(d), in accordance with the regulations at 42 CFR 434.27. This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.</p> <p>___ Disenrollment rights are restricted for a period of ___ months (not to exceed 6 months).</p> <p>During the first month of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least twice per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.</p> <p>___ No restrictions upon disenrollment rights.</p>
1903(m)(2)(H), 1902(a)(52) of the Act P.L. 101-508 (section 4732)		<p>In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an entity having a contract under section 1903(m) when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.</p> <p>___ The agency elects to reenroll the above individuals who are ineligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.</p> <p>___ The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.</p>

\*Agency that determines eligibility for coverage.

TN No. 92-61 Approval Date 2/16/92 Effective Date 1/1/92  
Supersedes  
TN No. NEW HCFA ID: 7983E

Agency*	Citation(s)	Group Covered
42 CFR 435.217	<input checked="" type="checkbox"/> 4.	A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.
		

\*Agency that determines eligibility for coverage.

State: WYOMING

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

1902(a)(10)  
(A)(ii)(VII)  
of the Act

X 5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

X The State covers all individuals as described above.

     The State covers only the following group or groups of individuals:

- Aged
- Blind
- Disabled
- Individuals under the age of--
  - 21
  - 20
  - 19
  - 18
- Caretaker relatives
- Pregnant women

\*Agency that determines eligibility for coverage.

TN No. <u>94-011</u>	Supersedes	Approval Date <u>10/25/94</u>	Effective Date <u>7/1/94</u>
TN No. <u>91-14</u>			



DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
1600 Broadway, Suite 700  
Denver, CO 80202-4967



## **Region VIII**

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October 29, 2013

Teri Green, State Medicaid Agent  
Wyoming Division of Health Care Financing  
401 Hathaway Building  
Cheyenne, WY 82002

RE: Wyoming #13-006

Dear Ms. Green:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 13-006. This SPA concerns elimination of an income test for individuals for whom public agencies are assuming full or partial financial responsibility and children for whom there is in effect a State adoption assistance agreement.

Please be informed that this State Plan Amendment was approved on October 25, 2013 with an effective date of October 1, 2013. We are enclosing the CMS-179 and the amended plan page(s).

If you have any questions concerning this amendment, please contact Cindy Riddle at (303) 844-7116.

Sincerely,

/s/

Richard C. Allen  
Associate Regional Administrator  
Division for Medicaid & Children's Health Operations

CC: Chris Bass  
Lee Clabots, Deputy Director

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER:

13-006

2. STATE  
WYOMING

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE  
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

October 1, 2013

5. TYPE OF PLAN MATERIAL (*Check One*):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:

Section 1902(a)(10)(A)(ii)(VIII) of the Act and 42 CFR 435.222

7. FEDERAL BUDGET IMPACT:

a. FFY 2013 \$64,900

b. FFY 2014 \$64,900

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 2.2-A, page 14

Supplement 8a to Attachment 2.6A, page 5

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (*If Applicable*):

Attachment 2.2-A, page 14

10. SUBJECT OF AMENDMENT:

Elimination of an income test for individuals for whom public agencies are assuming full or partial financial responsibility and children for whom there is in effect a State adoption assistance agreement.

11. GOVERNOR'S REVIEW (*Check One*):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED: Delegated to Teri  
Green, State Medicaid Agent, Division of  
Healthcare Financing

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME: TERI GREEN

14. TITLE: STATE MEDICAID AGENT

15. DATE SUBMITTED: 09/12/13

16. RETURN TO:

TERI GREEN  
STATE MEDICAID AGENT  
DIVISION OF HEALTHCARE FINANCING  
6101 YELLOWSTONE ROAD, SUITE 210  
CHEYENNE, WY 82002

CC: CHRIS BASS, MANAGEMENT ASSISTANT  
(SAME ADDRESS)

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

9/12/13

18. DATE APPROVED:

10/25/13

19. EFFECTIVE DATE OF APPROVED MATERIAL:

10/1/13

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:

RICHARD C. ALLEN

22. TITLE:

ARA, DNICHO

23. REMARKS:

State: Wyoming

Agency*	Citation(s)	Groups Covered
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(Continued)	B.	<u>Optional Groups Other Than the Medically Needy</u>
1902(a)(10) (A)(ii)(VIII) of the Act	<u>X</u>	8. A child for whom there is in effect a State adoption assistance agreement (other than under title IV-E of the Act), who, as determined by the State adoption agency, cannot be placed for adoption without medical assistance because the child has special needs for medical or rehabilitative care, and who before execution of the agreement—
	<u>    </u>	a. Was eligible for Medicaid under the State's approved Medicaid plan;
	<u>    </u>	b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied Rather than the AFDC standards and methodologies.
	<u>X</u>	c. The State will <u>not</u> apply an income test for these children.
	<u>X</u>	d. The State will <u>not</u> apply a resource test for these children.
		The State covers individuals under the age of--
	<u>X</u>	21
	<u>    </u>	20
	<u>    </u>	19
	<u>    </u>	18

TN No: 13-006

Approval Date 10/25/13Effective Date 10-01-13Supersedes TN No. 91-14

Revision: HCFA-PM-91- (BPD)  
1991

ATTACHMENT 2.2-A  
Page 15  
OMB NO.: 0938-

State: WYOMING

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.230 10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act.

The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

- a. Based on need and paid in cash on a regular basis.
- b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.
- c. Available to all individuals in the State.
- d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.
  - (1) All aged individuals.
  - (2) All blind individuals.
  - (3) All disabled individuals.

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TN No. 91-14  
Supersedes

Approval Date 12/19/91

Effective Date 12/1/91

TN No. 86-6

HCFA ID: 7983E

ion: HCFA-PM-91- (BPD)  
1991

ATTACHMENT 2.2-A  
Page 16  
OMB NO.: 0938-

State: WYOMING

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Agency*	Citation(s)	Groups Covered
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**B. Optional Groups Other Than the Medically Needy**  
(Continued)

42 CFR 435.230	— (4)	Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
	— (5)	Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
	— (6)	Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
	— (7)	Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
	— (8)	Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
	— (9)	Individuals in additional classifications approved by the Secretary as follows:

TN No. 91-14  
Supersedes

Approval Date 12/19/91

Effective Date

to. 86-6

12/1/91

HCFA ID: 7983E

Revision: HCFA-PM-91- (BPD)  
1991

ATTACHMENT 2.2-A  
Page 16a  
OMB NO.: 0938-

State: WYOMING

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Agency*	Citation(s)	Groups Covered
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**B. Optional Groups Other Than the Medically Needy**  
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

☐ Yes.

☐ No.

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

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TN No. 91-14  
Supersedes

Approval Date 12/19/91

Effective Date  
12/1/91

TN No. 86-06

HCFA ID: 7983E

Revision: HCFA-PM-91- (BPD)  
1991

ATTACHMENT 2.2-A  
Page 17  
OMB NO.: 0938-

State: WYOMING

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.121  
42 CFR 435.230  
1902(a)(10)  
(A)(ii)(XI)  
of the Act

11. Section 1902(f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act.

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

- a. Based on need and paid in cash on a regular basis.
- b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.
- c. Available to all individuals in each classification and available on a Statewide basis.
- d. Paid to one or more of the classifications of individuals listed below:

- \_\_\_ (1) All aged individuals.
- \_\_\_ (2) All blind individuals.
- \_\_\_ (3) All disabled individuals.

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TN No. 92-02  
Supersedes

Approval Date 3/2/92

Effective Date  
12/1/91

TN No. 91-14

HCFA ID: 7983E

F :ion: HCFA-PM-91-  
1991

(BPD)

ATTACHMENT 2.2-A  
Page 18  
OMB NO.: 0938-

State: WYOMING

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

- |   |     |   |
|---|-----|---|
| — | (4) | Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.                           |
| — | (5) | Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.                          |
| — | (6) | Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.                       |
| — | (7) | Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230. |
| — | (8) | Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.   |
| — | (9) | Individuals in additional classifications approved by the Secretary as follows:   |

TN No. 91-14  
Supersedes

Approval Date 12/19/91

Effective Date 12/1/91

TN No. [Signature]

HCFA ID: 7983E



Revision: HCFA-PM-91-  
1991

(BPD)

ATTACHMENT 2.2-A  
Page 18a  
OMB NO.: 0938-

State: WYOMING

Agency\* Citation(s)

Groups Covered

B. Optional Groups Other Than the Medically Needy  
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

☐ Yes

☐ No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

TN No. 91-14  
Supersedes

Approval Date 12/19/91

Effective Date  
12/1/91

TN No. New

HCFA ID: 7983E

sion: HCFA-PM-91-  
1991

(BPD)

ATTACHMENT 2.2-A  
Page 19  
OMB No.: 0938-

State: WYOMING

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

42 CFR 435.231 <u>/X/</u> 1902(a) (10) (A) (ii) (V) of the Act	12.	Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to <u>ATTACHMENT 2.6-A</u> , page 6A.
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/ The State covers all individuals as described above.

/X/ The State covers only the following group or groups of individuals:

1902(a) (10) (A)  
(ii) and 1905(a)  
of the Act

<u>X</u>	Aged
<u>X</u>	Blind
<u>X</u>	Disabled
___	Individuals under the age of--
___	21
___	20
___	19
___	18
___	Caretaker relatives
___	Pregnant women

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TN No. 91-14  
Supersedes

Approval Date 12/19/91

Effective Date

File No. 87-05

12/1/91

HCFA ID: 7983E

sion: HCFA-PM-91-  
1991

(BPD)

ATTACHMENT 2.2-A  
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OMB NO.: 0938-

State: WYOMING

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Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

1902(e)(3)  
of the Act

13. Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in a medical institution, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Act.

Supplement 3 to ATTACHMENT 2.2-A describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.

1902(a)(10)  
(A)(ii)(IX)  
and 1902(l)  
of the Act

14. The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A:

- a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and
- b. Infants under one year of age.

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TN No. 92-62  
Supersedes

Approval Date 3/2/92

Effective Date  
12/1/91

TN No. 91-14

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Revision: HCFA-PM-91-  
1991

(BPD)

ATTACHMENT 2.2-A

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OMB NO.: 0938-

State: WYOMING

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy  
(Continued)

1902(a)(10) ☒  
(ii) (X)  
and 1902(m)  
(1) and (3)  
of the Act

16. Individuals--

- a. Who are 65 years of age or older or are disabled, as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group.
- b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and
- c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in ATTACHMENT 2.6-A.

TN No. 91-14  
Supersedes

Approval Date 12/19/91

Effective Date  
12/1/91

TN No. 87-5

HCFA ID: 7983E

Revision: HCFA-PM-91-8  
October 1991

(MB)

ATTACHMENT 2.2-A  
Page 23a  
OMB NO.:

State/Territory: WYOMING

Citation	Groups Covered
B. <u>Optional Groups Other Than the Medically Needy</u> (Continued)	
1906 of the Act	18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of <u>ONE</u> month.
1902(a)(10)(F) and 1902(u)(1) of the Act	19. Individuals entitled to elect COBRA and continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent set of services. See Supplement 11 to Attachment 2.6-A.
1902(a)(10)(a)(ii) and 1902 (z) of the Act	20. Individuals not described in <del>1902(a)(10)(A)(i) of the Act who are infected with tuberculosis whose income and resources do not exceed the maximum amounts described in Supplement 14 to Attachment 2.6A.</del>

TN No. 94-012  
Supersedes Approval Date 11/21/94 Effective Date 7/1/94  
TN No. 93-007

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Wyoming

Citation	Groups Covered
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B. Optional Coverage Other Than the Medically Needy  
(Continued)

The following reasonable classifications of children described above who are under age \_\_\_\_ (18, 19) with family income at or below the percent of the Federal poverty level specified for the classification:

(ADD NARRATIVE DESCRIPTION(S) OF THE REASONABLE CLASSIFICATION(S) AND THE PERCENT OF THE FEDERAL POVERTY LEVEL USED TO ESTABLISH ELIGIBILITY FOR EACH CLASSIFICATION.)

1902 (e) (12) of the Act	<u>  X  </u>	22.	A child under age <u>19</u> (not to exceed age 19) who has been determined eligible is deemed to be eligible for a total of <u>12</u> months (not to exceed 12 months) regardless of changes in circumstances other than attainment of the maximum age stated above.
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1920A of the Act	<u>      </u>	23.	<u>Children under age 19 who are determined by a "qualified entity" (as defined in §1920A (b) (3) (A) ) based on preliminary information, to meet the highest applicable income criteria specified in this plan.</u>
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The presumptive period begins on the day that the determination is made. If an application for Medicaid is filed on the child's behalf by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on the day that the State agency makes a determination of eligibility based on that application. If an application is not filed on the child's behalf by the last day of the month following the month the determination of presumptive eligibility was made, the presumptive period ends on that last day.

TN No. 01-001  
Supersedes  
TN No. 00-007

Approval Date 01/18/01 Effective Date 04/01/2001

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Wyoming

Citation	Groups Covered	
	B.	<u>Optional Coverage Other Than the Medically Needy</u> (Continued)
1902 (a) (10) (A) (ii) (XVIII) of the Act	<u>X</u>	25. Women who: <ul style="list-style-type: none"><li>(i) have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix;</li><li>(ii) are not otherwise covered under creditable coverage, as defined in Section 2701 of the Public Health Service Act;</li><li>(iii) are not eligible for Medicaid under any mandatory categorically needy eligibility group; and</li><li>(iv) have not attained age 65.</li></ul>

N No. 01-008  
Supersedes  
TN No. NEW

Approval Date 10/18/01Effective Date 10/01/2001

Revision: HCFA-PM-91- (BPD)  
1991

ATTACHMENT 2.2-A  
Page 24  
OMB NO.: 0938-

State: WYOMING

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Agency*	Citation(s)	Groups Covered
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C. Optional Coverage of the Medically Needy

42 CFR 435.301 This plan includes the medically needy.

/X/ No.

/ Yes. This plan covers:

1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.

1902(e) of the Act

2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.

1902(a)(10)  
(C)(ii)(I)  
of the Act

3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.

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TN No. 92-02  
Supersedes

Approval Date 3/2/92

Effective Date  
12/1/91

Replaces 91-14

HCFA ID: 7983E



Approval on 6/12/14

Revision: HCFA-PM-91-  
1991

(BPD)

ATTACHMENT 2.2-A

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OMB NO.: 0938-

State: WYOMING

Agency*	Citation(s)	Groups Covered
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C. Optional Coverage of Medically Needy (Continued)1902(e) (4) of  
the Act

4. ~~Newborn children born on or after October 1, 1984 to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year so long as the woman remains eligible and the child is a member of the woman's household.~~

42 CFR 435.308

5. ☒ a. Financially eligible individuals who are not described in section C.3. above and who are under the age of--

☐ 21  
☐ 20  
☐ 19  
☐ 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training

☐ b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below:

☐ (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

☐ (a) In foster homes (and are under the age of \_\_\_\_).

☐ (b) In private institutions (and are under the age of \_\_\_\_).

TN No. 91-14  
SupersedesApproval Date 12/19/91

Effective Date

TN No. 86-612/1/91

HCFA ID: 7983E

Revision: HCFA-PM-91-8 (BPD)

October 1991

ATTACHMENT 2.2-A

Page 26a

OMB NO.: 0938-

State: WYOMING

Citation(s)

Groups Covered

C. Optional Coverage of Medically Needy  
(Continued)

1906 of the  
Act

12. Individuals required to enroll in  
cost effective employer-based group  
health plans remain eligible for a minimum  
enrollment period of \_\_\_\_\_ months.

NOT APPLICABLE

93-001  
Revised 2/18/93  
Effective Date 1/1/93  
Supersedes Transmittal NEW

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Wyoming

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE  
PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Agency	Citation(s)	Groups Covered
	1935(a) and 1902(a)(66)	The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act.
	42 CFR 423.774 and 423.904	<ol style="list-style-type: none"><li>1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act;</li><li>2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined;</li><li>3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.</li></ol>

TN No. 05-003

Approval Date 11/16/05

Effective Date July 1, 2005

Supersedes

TN No. NEW



# Department of Health

## Division of Health Care Financing

JIM GERINGER, GOVERNOR

97 MAR 4 AM 10 36

February 26, 1997

REF: SK-97-0041

Mary K. Smith  
Regional Administrator  
Health Care Financing Administration  
1961 Stout Street  
Denver, CO 82904-3538


ATTACHMENT 2.2-A  
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RE: Medicaid State Plan, Eligibility Coverage Groups

Dear Ms. Smith:

This letter is to advise you that it is the State of Wyoming's intent to not cover any optional alien groups under its approved plan. This election, effective January 2, 1997 is made to coincide with Wyoming's Temporary Assistance for Needy Families state plan.

Yours truly,

  
Sharon Kuster  
Interim Administrator

SK:MY:rd

c: Cyndi Gillaspie, Department of Family Services  
Medicaid Eligibility Unit  
Maureen Yaksic, Division of Health Care Financing  
Jana Gizinski, Division of Health Care Financing

TRANSMITTAL NO. 97-002  
Date Approved 05/21/97  
Effective Date 01/01/97  
Supersedes Transmittal NEW