Health, Department of

Medicaid

Chapter 18: Medicaid Eligibility

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CHAPTER 18

Medicaid Eligibility

Section 1. Authority. The Wyoming Department of Health (Department) promulgates this Chapter pursuant to the Wyoming Medical Assistance and Services Act at Wyoming Statute § 42-4-101 through -124.

Section 2. Purpose and Applicability.

(a) The Department adopts this Chapter to govern Medicaid eligibility and enrollment including an individual's rights and responsibilities, establishing uniform application and renewal procedures and defining eligibility groups.

(b) This Chapter applies to all applicants and clients for all eligibility determinations.

(c) The Department may issue manuals and bulletins to interpret 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 this Chapter.

Section 3. Definitions.

(a) Except as otherwise specified in Wyoming Medicaid Rules Chapter 1, or as defined herein, 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.

(d) A "Personal Care Contract" means an agreement between a caregiver and an aged, blind or disabled individual to provide caregiver services for fair market value.

Section 4. Application Process, Applicant/Client 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 for 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 Department or designee. If future medical evidence is required to assess the applicant's duration of disability, a medical deferment of up to ninety (90) additional days for processing is authorized.

(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 for 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 Wyo. Stat. § 42-4-108.

(iv) Any individual who has been determined eligible by the Social Security Administration (SSA) 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/Client 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.

(iii) Applicants, clients, and their representatives shall report changes in any of the following circumstances to the Department within ten (10) days:

(A) Income;

(B) Resources, if applicable to their program;

(C) Household composition;

(D) Health insurance coverage; and

(E) Address.

(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, when 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 client'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 specified in the Wyoming Medicaid State Plan. An individual who intends to return to their home 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.

Section 6. Family and Children's Eligibility.

(a) The following are Medicaid-eligible categories:

(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 who 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 Wyoming 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 or Tribal custody under a Federally Funded Foster Care Medicaid program 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) Children who were in any State's or Tribal custody under a Federally Funded Foster Care Medicaid program 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), if the child turned eighteen (18) on or after January 1, 2023.

(ix) 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 twelve (12) month postpartum period beginning on the last day of the pregnancy.

(x) A woman who is pregnant and whose family income does not exceed the income eligibility levels specified in the Wyoming Medicaid State Plan under Title XIX of the Social Security Act shall be eligible for Medicaid during the pregnancy and through a twelve (12) month postpartum period beginning on the last day of the pregnancy.

(xi) 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.

(xii) 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.

(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 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.

(xiv) 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 twelve (12) months.

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

(b) For all eligibility categories described in this Section 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 this Section.

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 day of the month following the month in which the determination of presumptive eligibility was made if no full Medicaid application is received.

(b) Presumptive eligibility determinations may be conducted by a:

(i) Qualified provider; or

(ii) Qualified hospital

(c) Presumptive eligibility shall be limited to the following categories:

(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 Wyoming Medicaid 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 Wyoming Medicaid State Plan for this group. The individual shall be eligible for one (1) presumptive eligibility period every twelve (12) months.

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

(v) Children who were in any State's or Tribal custody under a Federally Funded Foster Care Medicaid program 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). The individual shall be eligible for one (1) presumptive eligibility period every twelve (12) months.

(d) Status as a qualified provider or qualified hospital may be terminated if a staff member of the provider or hospital knowingly provides false information to influence a presumptive eligibility determination. Providers may request reconsideration of the disqualification in accordance with Wyoming Medicaid Rules Chapter 4.

Section 8. Aged, Blind or Disabled Eligibility.

(a) The following are Medicaid-eligible categories:

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

(ii) Determined disabled according to Social Security guidelines by the SSA or the Department

(iii) Entitled to or receiving SSI, or SSI-related programs; or

(iv) Individuals who receive hospice services in accordance with a voluntary election, and provider statement of terminal condition when:

(A) The individual has received hospice services, or resided in a medical institution, for thirty (30) or more consecutive days; or

(B) The individual is not an SSI recipient and dies before completion of the thirty (30) consecutive days' requirement.

(v) Individuals who qualify for Home and Community Based Services (HCBS) under a Medicaid waiver pursuant to Medicaid Rules Chapters 34 and 46.

(b) In order to qualify for an Aged Blind or Disabled (ABD) program, the individual must also meet established level of care requirements, and income and resource guidelines applicable to the client's program as detailed in the Medicaid Eligibility Online Manual.

(c) Treatment of Income.

(i) Income of a spouse is not available to the other spouse when applying for Inpatient Hospital Care, the Employed Individuals with Disabilities (EID) program, Nursing Home Care, Hospice Care, or HCBS 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) consecutive days, or if the child applies for assistance under a HCBS waiver or the EID program.

(iii) Income within a valid income trust may qualify for an income trust exemption, pursuant to Section 1917(d)(4)(B) of the Social Security Act. An income trust cannot be used to qualify an applicant/client for inpatient hospital or hospice Medicaid programs. Penalties for transferred resources shall not apply to resources transferred into an income trust. To qualify as a valid income trust, the trust must:

(A) Be established using standards provided by the Department;

(B) Be irrevocable;

(C) Be composed only of pension, Social Security, and other income to the individual and accumulated income in the trust;

(D) 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;

(E) 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;

(F) 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

(G) Prohibit any portion of the trust principal to be available to the beneficiary.

(d) Treatment of Resources.

(i) Resources belonging to an applicant or their spouse are considered available determining Medicaid eligibility if either has the legal right, authority, or power to liquidate them. At renewal, only resources available to the client are considered when redetermining eligibility as specified in 20 C.F.R. 416.1201 et seq.

(ii) Resources belonging to an applicant or their spouse are considered unavailable when determining Medicaid eligibility if there is a legal barrier that prevents the access or right to dispose of the resource. The applicant/client 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 value of the resource or that it is unlikely the legal action would be successful.

(iii) A home, as defined by Chapter 1 of the Wyoming Medicaid Rules, is an excluded resource. If the applicant/client resides in an institution and does not have a community spouse, their intent to return home must be established by execution of the Department's intent to return home form.

(iv) Real property shall be considered unavailable to the individual for purposes of determining resources when the individual has executed:

(A) The Department's conditional benefits agreement form when the individual has been eligible for Medicaid for less than six (6) months; or

(B) The Department's bona fide effort to sell agreement when the individual has been eligible for Medicaid for six (6) months or more.

(v) 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 Wyo. Stat. § 42-7-102(a)(v).

(vi) Resources shall not exceed the SSI resource limits, except as specified in 20 C.F.R. § 416.1205. Individuals who are ABD and reside in a medical institution, receive Hospice Services, or receive HCBS under a waiver shall receive an additional Community Spouse Resource Maintenance Allowance (CSRMA) as specified in Section 1924 of the of the Social Security Act.

(e) Treatment of Trusts.

(i) Revocable and irrevocable trusts shall be treated in accordance with Wyo. Stat. §§ 42-2-402, 42-2-403, and the Social Security Act, 42 U.S.C. 1396p.

(ii) All trust distributions to or for the benefit of the beneficiary client, unless paid directly to a third party, shall be income to the client in the month received and a client resource the first of the month following.

(iii) Special needs trusts established in accordance with Wyo. Stat. §§ 42-2-402, 42-2-403, and the Social Security Act, 42 U.S.C. 1396p shall be considered an excluded resource when the following conditions are met:

(A) The individual trust account holder must be under age sixty-five (65) and determined disabled according to the criteria set forth in 42 U.S.C. § 1382(c)(a)(3) when the trust is established;

(B) The trust is irrevocable;

(C) The trust prohibits any portion of the principal to be available to the beneficiary;

(D) Trust resources from a third party are considered an irrevocable gift. 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;

(E) The trust includes a valid "spendthrift clause" that complies with the laws of every state in which the individual has received Medicaid benefits;

(F) The trust lists the Department as a Qualified Beneficiary as defined in Wyo. Stat. § 4-10-103(a)(xv)(E);

(G) Trust distributions shall be for the sole benefit of the disabled beneficiary and shall be used to provide for the beneficiary's special needs; and

(H) Trust distributions shall be allowed for the beneficiary's basic needs only when the trustee has proven to the Department that the beneficiary's basic needs are not adequately met by government assistance programs.

(iv) Administrative requirements for a special needs trust are as follows:

(A) When a 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.

(B) 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.

(C) Trust 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;

(D) The trustee shall obtain the consent of the Department prior to early termination of a special needs trust pursuant to Wyo. Stat. § 4-10-412. The Department shall consent to termination of a special needs trust prior to the beneficiary's death when a court order is entered providing that the Department shall be fully reimbursed from the trust. The Department shall be joined as a party to any such proceedings and served with a copy of all pleadings; and

(E) When the beneficiary dies or the trust is terminated, the trustee shall notify the Department and provide a sworn affidavit with an accounting within sixty (60) days after the beneficiary's death.

(v) Assets of an individual deposited into a Department-approved pooled trust account established in accordance with Wyo. Stat. § 42-2-403(f)(iii) and 42 U.S.C. § 1396p shall be considered an excluded resource when the following conditions are met:

(A) The individual trust account holder must be determined disabled according to the criteria set forth in 42 U.S.C. § 1382(c)(a)(3) when the account is established;

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

(C) A separate account is maintained for each beneficiary of the trust but is pooled for the purposes of investment and management of funds;

(D) Accounts in the trust are established solely for the benefit of disabled individuals as defined by 42 U.S.C. § 1382(c)(a)(3), by the disabled individual, parent, grandparent, legal guardian, or by a court; and

(E) Pooled trust distributions shall be for the sole benefit of the disabled beneficiary and shall be used to provide for the beneficiary's special needs.

(vi) Administrative requirements for a pooled trust are as follows:

(A) Any distribution from the trust paid directly to the beneficiary shall be considered income available to the beneficiary in the month received and a resource the first of the month following;

(B) The trustee shall obtain the consent of the Department prior to early termination of a special needs trust pursuant to Wyo. Stat. § 4-10-412. The Department shall consent to termination of a special needs trust prior to the beneficiary's death when a court order is entered providing that the Department shall be fully reimbursed from the trust. The Department shall be joined as a party to any such proceedings and served with a copy of all pleadings;

(C) When the beneficiary dies or the trust is terminated, the trustee shall notify the Department and provide a sworn affidavit with an accounting within sixty (60) days after the beneficiary's death;

(D) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary, or termination of the pooled trust, are not retained by the trust, the trust pays to the state from the remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary, except for reasonable administrative fees and expenses agreed upon by the Department;

(E) 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;

(f) Personal Care Contracts

(i) Payments made to family members through a personal care contract (PCC) to delay or prevent Medicaid long term services or support are authorized, but shall be considered a transfer of resources for less than fair market value unless the agreement meets the requirements in this Section and documentation is provided to the Department upon request.

(ii) The PCC shall be in writing and must include:

(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 under 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 retroactive PCC shall be considered a transfer for less than fair market value in accordance with subsection (i) of this Section.

(g) Patient Contribution for Institutional Care.

(i) The patient contribution is the monthly amount a Medicaid eligible individual must pay toward their cost of care or services and is based upon their gross income.

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

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

(iv) Deductions for a spouse who lives in the community when the married client lives in a medical institution, shall be applied in accordance with Title XIX of the Social Security Act, 42 C.F.R. § 435.725 and the Wyoming Medicaid State Plan.

(v) 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 their home as defined in Medicaid Rules Chapter 1, when:

(A) A physician verifies the individual can return to their home within six (6) months; and

(B) The client's spouse is not institutionalized.

(h) Medicaid benefits are authorized:

(i) After completion of thirty (30) consecutive days in a medical institution, thirty (30) days after a hospice election, or upon the client's death in the facility or while receiving services under a hospice election before the thirty (30) consecutive days has been met.

(ii) The first day of the month during which all eligibility requirements are met and the client's individual plan of care is approved by the Department for an HCBS waiver program.

(i) Transfer of Resources:

(i) It is presumed that a transfer of an individual's resource for less than fair market value was made for the purpose of qualifying for Medicaid. Unless convincing evidence is submitted to the Department that the resource was transferred exclusively for some other reason. The burden of rebutting the presumption that a resource was transferred to establish Medicaid eligibility rests with the individual.

(ii) The fair market value of real property shall be based on an appraisal or a comparative 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 comparative market analysis. Failure to provide the requested documentation shall result in a denial of eligibility.

(iii) 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.

(iv) Services provided for free at the time performed were intended to be provided without compensation. A retroactive transfer of a resource for care provided in the past

without compensation is presumed a transfer for less than fair market value. An individual can rebut this presumption with tangible evidence that is acceptable to the Department as described in subsection (e) of this Section. Such evidence shall be in writing at the time services were provided to be considered by the Department.

(v) A transfer penalty shall not be imposed if the transferred resource is returned to the individual. A one-time return, or one-time partial return, of the transferred resource, can be made to the individual or paid directly to a provider during the transfer penalty period in order to reduce or eliminate the transfer penalty. The value of returned resources shall be determined using fair market value.

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

(vi) The Department shall waive a transfer penalty if imposing the penalty would result in undue hardship as determined by the Department. The Department shall consider a waiver of the transfer penalty for undue hardship when requested by an individual using the Department's hardship request form with supporting documentation and a physician statement, as applicable.

(A) Undue hardship exists when a transfer penalty would deprive the individual of food, clothing, shelter, or other necessities of life, or deprive the individual of medical care such that the individual's health or life would be endangered and one of the following:

(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.

Section 9. Breast and Cervical Cancer Program.

(a) Eligibility Requirements:

(i) Referral to the Medicaid Breast and Cervical Cancer Program by the Department's Public Health Division Breast and Cervical Cancer Early Detection Program;

(ii) Countable family income less than or equal to two hundred and fifty percent (250%) of the FPL. Income shall be calculated using the modified adjusted gross income of the household, as specified in 42 C.F.R. § 435.603 and the Wyoming Medicaid State Plan;

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

(iv) Individuals shall not be eligible for other full Medicaid programs, or have health insurance.

(b) 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 as outlined in Section 4(c)(iii), as well as the conclusion of their treatment.

Section 10. Employed Individuals with Disabilities Program.

(a) Medicaid benefits are available to individuals with disabilities who work and pay a monthly premium for their healthcare coverage under the Employed Individuals with Disabilities (EID) program.

(b) Eligibility Requirements:

(i) Countable unearned income shall be less than or equal to three hundred percent (300%) of the 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 will be considered employed while on a temporary absence from work due to documented medical leave.

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

(c) An individual who meets the EID eligibility requirements may receive waiver services through the EID Comprehensive or Supports waiver if they meet other HCBS criteria for the Comprehensive or Supports waivers.

(d) Individuals shall be responsible for reporting to the Department any changes as outlined in Section 4(c)(iii), as well as any changes to employment.

Section 11. Medicare Savings Programs.

(a) Medicaid shall assist individuals eligible for the Qualified Medicare Beneficiary (QMB) program 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 FPL; and,

(iii) Countable resources shall not exceed the resource limit established by the SSA adjusted annually by the increase in the consumer price index.

(b) Medicaid shall assist individuals eligible for the Specified Low-Income Medicare Beneficiary (SLMB) program 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 equal to one hundred twenty percent (120%) of the FPL.

(iii) Countable resources shall not exceed the resource limit established by the SSA, adjusted annually by the increase in the consumer price index.

(c) Medicaid shall assist individuals eligible for the Qualified Individual (QI) program 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; and,

(iii) Countable resources shall not exceed the resource limit established by the Social Security Administration adjusted annually by the increase in the consumer price index.

(d) Medicaid shall assist individuals eligible for the Qualified Disabled Working Individual (QDWI) program with paying their Medicare Part A premiums, as specified in

Section 1902(a)(10)(E)(ii) of the Social Security Act. Individuals shall meet the following eligibility requirements:

(i) Be disabled according to Social Security guidelines, are ineligible for Social Security Disability Income (SSDI) and premium-free Medicare Part A benefits due to returning to work;

(ii) Countable income shall be at or below two hundred percent (200%) of the FPL;

(iii) Countable resources shall not exceed twice the limit of the SSI resource limit; and,

(iv) Not otherwise eligible for another Medicaid program.

(e) Eligibility shall be redetermined by the Department every twelve (12) months for all groups within this section.

(f) Individuals shall be responsible for reporting to the Department any changes described in Section 4(c)(iii).

Section 12. Emergency Services Program. Applicants who are not citizens or nationals of the United States, but otherwise meet the eligibility requirements of the following Medicaid programs, are eligible for limited emergency services as specified in 42 C.F.R. § 440.255: Modified Adjusted Gross Income-Based (MAGI) programs; the Inpatient Hospital program; and, the SSI program solely for retroactive months.

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.