

Wyoming Administrative Rules

Health, Department of

Medicaid

Chapter 18: Medicaid Eligibility

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CHAPTER 18

MEDICAID ELIGIBILITY

Section 1. Authority.

This Chapter is promulgated pursuant to Title XIX of the Social Security Act, 20 C.F.R., Chapter III, Part. 416; 42 C.F.R., Chapter IV, Subchapter C, Part 435; 45 C.F.R., Subtitle B, Chapter II, Part 233; the Medical Assistance and Services Act at Wyoming Statutes § 42-4-101 through 42-4-306; Wyoming Statute § 42-4-104; and Wyoming Statute § 9-2-106.

Section 2. Purpose and Applicability.

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

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

Section 3. Definitions.

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

Section 4. Application Process, Applicant Rights and Responsibilities.

(a) Application Process.

(i) Applicants shall submit an application in the manner and form prescribed by the Department, except when the individual is eligible for Supplemental Security Income (SSI). The application shall be completed, dated, and signed by the applicant or by any person who is assisting the applicant.

(A) Any individual who knowingly makes a false statement or misrepresentation or knowingly fails to disclose a material fact in obtaining benefits may be guilty of a misdemeanor or felony, as specified in Wyoming Statute § 42-4-111.

(ii) Applications shall be acted on 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 verification from a third party, or

(III) Ninety (90) days from the date of application when waiting for a disability determination.

(B) Family and Children's programs:

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

(iii) Applicants shall be notified in writing of the reasons for the action, the specific regulation supporting the action, and an explanation of the right to request a hearing, as specified in 42 C.F.R. §§ 431.206 and 431.210.

(iv) A record of all action taken shall be documented in the case file, as specified in 42 C.F.R. § 435.914.

(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, as specified in 42 C.F.R. § 435.915, 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, as required by 42 C.F.R. § 435.906.

(ii) Applicants may be accompanied, assisted, or represented by an individual or individuals of their choice during the application process, as required by 42 C.F.R. § 435.908.

(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 applicants and clients.

(v) Confidentiality. Applications and other personal identifying information are confidential and shall not be disclosed, except as follows:

(A) To ensure any medical assistance does not duplicate any benefit payment made by another state agency, insurer, group health plan, third party administrator, health maintenance organization or similar entity, upon request of the state

agency, insurer or similar entity, the Department may disclose the client's name, social security number, amount of payment, charges for services, dates of services, and services rendered, as provided by Wyoming Statute § 42-4-112.

(B) To ensure any medical assistance does not duplicate any benefit payment made by another state agency, insurer or similar entity, the Department may request the limited information listed in (A) above from such entities.

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

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

(c) Applicant Responsibilities.

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

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

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

(d) Eligibility Period and Redeterminations.

(i) Effective Dates of Benefits.

(A) Begin dates. Medicaid eligibility begins the first day of the month in which the individual is eligible, as specified in 42 C.F.R. § 435.915 and the Medicaid State Plan under Title XIX of the Social Security Act, except that eligibility under the Presumptive Programs, eligibility begins the day the application is submitted and approved, as specified in Section 1920 of the Social Security Act.

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

(ii) Redetermination of Eligibility. The Agency shall redetermine an individual's eligibility every 12 months.

Section 5. General Eligibility Requirements. In addition to meeting the requirements under Section 6 (Family and Children's Eligibility), Section 8 (Aged, Blind or Disabled Eligibility), Section 9 (Special Eligibility Groups), or Section 10 (Employed

Individuals with Disabilities Eligibility Group), Section 11 (Medicare Savings Programs) of this Chapter, applicants shall meet the following requirements to be eligible for Medicaid:

(a) Citizenship and Alienage. Applicants shall be citizens or nationals of the United States, as specified in 42 C.F.R. § 435.406. Applicants who are not citizens or nationals of the United States, but otherwise meet the eligibility requirements of the State Plan, are eligible for limited emergency services, as specified in 42 C.F.R. § 440.255, except as set forth in Section 12 of this Chapter.

(i) Pregnant women considered to be lawfully present satisfy the citizenship and alienage eligibility requirements.

(b) Identification. Applicants shall provide proof of identity, as specified in 42 C.F.R. § 435.407.

(c) Residency. Applicants shall reside in Wyoming or meet the criteria, as specified in 42 C.F.R. § 435.403.

(d) Social Security Number. Applicants who are citizens or nationals of the United States shall provide a social security number.

Section 6. Family and Children's Eligibility.

(a) The following individuals are eligible for Medicaid:

(i) Children born to a Medicaid eligible woman are deemed to have applied for medical assistance and to have been found eligible on the date of birth and to remain eligible for a period of 13 months, as specified in 42 C.F.R. § 435.117.

(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), are eligible for Medicaid as specified in 42 C.F.R. § 435.118 .

(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 are eligible for Medicaid as specified in 42 C.F.R. § 435.118.

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

(v) Foster care children who are not eligible under Title IV-E of the Social Security Act and are in the custody of the Department of Family Services (DFS) are eligible for Medicaid, as specified in 42 C.F.R. § 435.222.

(vi) Adopted children who live in Wyoming and are under a Wyoming Subsidized Adoption Agreement remain eligible for Medicaid until age twenty-one (21), as specified in 42 C.F.R. § 435.145, 42 C.F.R. § 435.222 and Section 1902 (a)(10)(A)(ii)(VIII) of the Social Security Act.

(vii) Children who were in DFS custody at the time of their eighteenth (18th) birthday and are released from custody at that time or later, as specified in Sections 1902(a)(10)(A)(ii)(XVII) and 1905(w)(1) of the Social Security Act, are eligible for Medicaid until age twenty-six one (21).

(viii) Children who were in DFS custody at the time of their eighteenth (18th) birthday and were receiving Medicaid benefits under the State Plan at that time or later, as specified in 42 C.F.R. § 435.150, shall be eligible for Medicaid until age twenty-six (26)

(ix) Poverty-Level Pregnant Women. A woman who is pregnant and whose family income does not exceed one hundred fifty-four percent (154%) of the FPL is eligible for Medicaid during the pregnancy and through a sixty (60) day period beginning on the last day of the pregnancy, as specified in 42 C.F.R. § 435.116.

(x) Qualified Pregnant Women. A woman who is pregnant and whose family income does not exceed the income eligibility levels specified in the Medicaid State Plan under Title XIX of the Social Security Act shall be eligible for Medicaid during the pregnancy and through a sixty (60) day period beginning on the last day of the pregnancy, as specified in 42 C.F.R. § 435.116, and Sections 1902(a)(10)(A)(i)(III) and 1905(n)(1) of the Social Security Act. Qualified Pregnant Women shall cooperate in establishing paternity, and obtaining medical support during the sixty (60) day postpartum period, as specified in 42 C.F.R. § 433.147

(xi) Family Planning Waiver. A woman who is age nineteen (19) but under the age of forty-five (45), whose family income does not exceed one hundred fifty-nine percent (159%) of FPL and is transitioning from the Pregnant Women Program shall be eligible for Medicaid coverage for certain family planning services as specified in 42 C.F.R. § 435.214 and Section 1115(a) of the Social Security Act.

(xii) Family Care. 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, as specified in 42 C.F.R. § 433.147 and Section 1931 of the Social Security Act.

(xiii) Four (4) Month Extended Medicaid. Caretaker relatives of a dependent child under the age of nineteen (19) 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, as specified in 42 C.F.R. § 435.115.

(xiv) Twelve (12) Month Extended Medicaid. Caretaker relatives of a dependent child under the age of nineteen (19) 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 Medicaid for an extended period of time, as specified in 42 C.F.R. § 435.112.

(xv) Tuberculosis Assistance Program. Medicaid benefits shall be available to individuals who are infected with tuberculosis, as specified in 42 C.F.R. § 435.215.

(b) Treatment of Income.

(i) For all eligibility categories described in Section 6(a) of this Chapter which include an income requirement, income shall be calculated using the modified adjusted gross income of the household, as specified in 42 C.F.R. § 435.603 and the State Plan.

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

(d) Reporting Changes. Clients shall immediately report changes in any of the following circumstances to the Department:

- (i) Income;
- (ii) Household composition;
- (iii) Health insurance; and
- (iv) Address.

Section 7. Presumptive Eligibility.

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

- (i) The day on which a Medicaid application is given a determination;
- or
- (ii) The last of day of the month following the month in which the determination of presumptive eligibility was made.

(b) Presumptive Eligibility determinations may be conducted by:

- (i) Qualified providers, as specified in Social Security Act § 1920; or
- (ii) Qualified Hospitals, as specified in 42 C.F.R. § 435.1110.

(c) Presumptive Eligibility shall be limited to:

(i) Pregnant women whose family income does not exceed one hundred fifty-four percent (154%) of FPL shall be eligible for temporary outpatient services, as specified in Sections 1902(a)(47) and 1920 of the Social Security Act. A pregnant woman shall be eligible for one (1) presumptive eligibility period per pregnancy.

(ii) Children under age six (6) whose family income does not exceed one-hundred fifty-four percent (154%) of FPL and children age six (6) through eighteen (18) whose family income does not exceed one-hundred thirty-three percent (133%) of FPL shall be eligible for all services covered under the State Plan, as specified in 42 C.F.R. § 435.1102. A child shall be eligible for one (1) presumptive eligibility period every twelve (12) months.

(iii) Eligibility groups specified in 42 C.F.R. § 435.1102 and 42 C.F.R. § 435.1103 that are elected in the State Plan.

(d) Status as a qualified provider or qualified hospital may be terminated if staff at a qualified provider or qualified hospital knowingly provides false information to influence a presumptive eligibility determination. Providers may seek corrective action by contacting the Department or requesting an Administrative Hearing pursuant to Chapter 4 of the Medicaid Rules.

(e) Presumptive Eligibility determinations must be made in accordance with Department policy, 42 C.F.R. § 435.1101, 42 C.F.R. § 435.1102, and 42 C.F.R. § 435.1110.

Section 8. Aged, Blind or Disabled Eligibility.

(a) Eligibility Requirements.

(i) Aged, Blind, or Disabled. The applicant/client shall be:

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

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

(C) An individual who is determined disabled by the SSA or the Department, as specified in Section 1614(a)(3) of the Social Security Act; 42 C.F.R. Chapter IV, Subchapter C, Part 435, Subpart F; and 20 C.F.R. Chapter III, Part 416, Subpart I.

(b) The following individuals are eligible for Medicaid:

(i) Individuals entitled to Supplemental Security Income (SSI), as specified in Section 1902(a)(10)(A)(i)(II) of the Social Security Act.

(ii) Any aged, blind, or disabled individual who loses eligibility for Supplemental Security Income (SSI) benefits due to an increase in income, but who would be eligible for SSI if the Cost of Living Adjustments (COLA) received since the SSI termination were disregarded, as specified in 42 C.F.R. § 435.135.

(iii) A child who was receiving SSI on the date of the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and lost SSI due to the new definition of disability, as determined by the SSA.

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

(v) Individuals who are Aged, Blind or Disabled and reside in a medical institution, receive hospice services in accordance with a voluntary election, or receive Home and Community Based Services (HCBS) under a waiver pursuant to Section 1915(c) of the Social Security Act and have income at or below three hundred percent (300%) of the Supplemental Security Income (SSI) payment standard, as specified in 42 C.F.R. § 435.1005. Individuals shall reside in a medical institution for thirty (30) consecutive days or more, unless the individual is eligible for SSI or dies before completion of the thirty (30) consecutive days, as specified in Section 1902(a)(10)(A)(ii)(V) of the Social Security Act.

(c) Treatment of Income.

(i) Income of a spouse is available to the other spouse for individuals described in Section 8(a) above.

(ii) A parent's income is available to a child until the month after the child attains age eighteen (18) if the child lives in the parent's home. A parent's income is not available to a child if the child is married, institutionalized for more than thirty (30) days, or if the child applies for assistance under a Home and Community Based Services waiver pursuant to Section 1915(c) of the Social Security Act or the Employed Individuals with Disabilities program.

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

(iv) To qualify for an Income Trust exception, as specified in Section 1917 of the Social Security Act and Wyoming Statute § 42-2-403:

(A) The trust shall be irrevocable.

(B) The trust shall be composed only of pension, Social Security, and other income to the individual and accumulated income in the trust;

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

(D) The trust shall allow a monthly distribution of three hundred percent (300%) of the Supplemental Security Income Federal Payment, as prescribed in 42 C.F.R. § 435.1005, for programs with no patient contribution, reasonable costs of administering the trust, and a Community Spouse allowance according to Section 1924 of the Social Security Act.

(E) The trust shall 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.

(F) No portion of the principal shall be considered available to the individual.

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

(d) Treatment of Resources.

(i) Resources shall be available to the applicant or client when the applicant or client has the legal right, authority, or power to make the resource available, as specified in 20 C.F.R. Chapter. III, Part 416, Subpart L.

(ii) Resources shall be determined to be unavailable to the applicant or client when there is a legal impediment that precludes the disposal of the resource. The applicant or client shall pursue reasonable steps to overcome the legal impediment unless it is determined by the Department that the cost of pursuing legal action would exceed the resource value of the property or that it is unlikely the applicant or client would succeed in the legal action.

(iii) Real property shall be determined to be unavailable if the property cannot be sold because the property is jointly owned and its sale would cause undue hardship through the loss of housing for the other owner or owners, or because reasonable efforts to sell the property have been unsuccessful.

(iv) Medicaid may disregard any resources claimed by an applicant or client in an amount equal to or less than the benefits paid on behalf of the individual by a Qualified Long-Term Care Partnership Policy.

(A) “Qualified Long-Term Care Partnership Policy” means a policy that meets all of the requirements as specified in Wyoming Statute § 42-7-102(a)(v).

(v) Resources shall not exceed the SSI resource limits, as specified in 20 C.F.R. § 416.1205, except that individuals who are Aged, Blind or Disabled and reside

in a medical institution, receive Hospice Services, or receive Home and Community Based Services under a waiver shall receive an additional Community Spouse allowance as specified in Section 1924 of the of the Social Security Act.

(vi) Trusts.

(A) Revocable Trusts. The principal of a revocable trust shall be an available resource when the applicant or client can revoke the trust and reclaim the trust resources.

(B) Irrevocable Trusts.

(I) The principal of an irrevocable trust shall be an available resource when:

(1.) The resources of the individual or spouse were used to form all or part of the principal of the trust; and

(2.) Payments from the trust could be made available to or for the benefit of the individual or spouse. The portion of the principal from which payments could be made available to or for the benefit of the individual or spouse shall be an available resource. If the terms of a trust provide for the support of the applicant or client, the refusal of a trustee to make a distribution from the trust does not render the trust an unavailable resource.

(II) The principal of an irrevocable trust shall be determined to be unavailable when the resources of someone other than the individual or spouse (i.e., a third party) were used to form the principal of the irrevocable trust unless the terms of the trust permit the individual to require the trustee to distribute principal or income to the individual or spouse.

(III) Payments made from the portion of the principal of an irrevocable trust to or for the benefit of the individual shall be income of the individual.

(C) Special Needs Trusts shall be established in accordance with Wyoming Statute § 42-2-403(f)(i) and Section 1917 of the Social Security Act.

(I) The Trustee shall obtain the consent of the Department prior to early termination of a Special Needs Trust pursuant to Wyoming Statute § 4-10-412. The Department shall consent to termination of a Special Needs Trust prior to the individual's death when a court order is entered providing that the Department shall be fully reimbursed from the Special Needs Trust

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

(III) To qualify for a Special Needs Trust exception and exclude the resources within the trust, the Special Needs Trust shall:

- (1.) Be irrevocable;
 - (2.) Be established for the sole benefit of an individual who is under age sixty-five (65) and disabled according to the criteria set forth in 42 U.S.C. § 1382c(a)(3);
 - (3.) Contain only the assets of a disabled individual who is under age sixty-five (65) when the trust is established. Any assets placed in the trust after age sixty-five (65) are not subject to the exception;
 - (4.) Be established by a parent, grandparent, legal guardian or a court consistent with Wyoming Statutes §§ 42-2-403(f), 4-10-401(a)(iv) and 3-3-607(a)(vi); and
 - (5.) Provide that the state shall receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total amount of medical assistance paid on behalf of the individual.
- (IV) The Trustee shall obtain the consent of the Department prior to early termination of a Special Needs Trust pursuant to Wyoming Statute § 4-10-412, and the Department shall be joined as a party to any such proceedings and served with a copy of all pleadings.
- (V) The Department is a Qualified Beneficiary pursuant to Wyoming Statute § 4-10-103 and shall consent to termination of a Special Needs Trust pursuant to Wyoming Statutes §§ 4-10-412 and 4-10-415 prior to death when a court order is entered providing that the Department shall be fully reimbursed from the Special Needs Trust.
- (VI) Distributions.
- (1.) Distributions from the Special Needs Trust shall be for the sole benefit of the disabled individual and shall be used to provide for the individual's special needs.
 - (2.) Distributions for funeral expenses shall not be paid after the beneficiary's death until the Department and all other state Medicaid agencies are fully reimbursed.
 - (3.) Distribution for basic needs shall only be allowed when the Trustee has proven to the Department that the disabled individual's basic needs are not adequately being provided for by government assistance programs.
- (VII) Contributions. All contributions from third parties to the trust shall be deemed a completed gift to the disabled individual, and the third party may not obtain a refund, redirect resources transferred to the trust, or otherwise exert any interest or control over the resources in the trust.

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

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

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

(XI) Principal. No portion of the principal shall be available to the individual.

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

(D) Pooled Trusts shall be established in accordance with Wyoming Statute § 42-2-403(f)(iii) and Section 1917 of the Social Security Act.

(I) To qualify for a Pooled Trust exception and exclude the resources, including the principal within the trust, the pooled trust shall:

(1.) Be irrevocable;

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

(3.) Be established and managed by a non-profit association;

(4.) Maintain a separate account and Joinder Agreement for each beneficiary, but for the purposes of investment and management of funds, the accounts are pooled; and

(5.) Provide that to the extent that amounts remaining in a beneficiary's account upon the death of the individual beneficiary are not retained by the trust, the trust pays to the state from the remaining amount in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.

(II) Distributions. The pooled trust shall provide that all distributions shall be for the sole benefit of the disabled individual and shall be used to provide for the individual's special needs.

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

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

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

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

(vii) Personal Care Contracts

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

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

(I) The date the care begins,

(II) A detailed description of the services to be provided,

(III) How often services will be provided,

(IV) How much the caregiver will be compensated,

(IV) When the caregiver will be compensated,

(V) How long the agreement is to be in effect,

(VI) A statement that the terms of the agreement can be modified only by mutual agreement of the parties,

(VII) The location where services will be provided, and

(VIII) The notarized signature of both parties.

(C) The following services may be provided through a PCC: preparing meals, shopping, medication management, transportation to medical appointments, paying bills, light housekeeping, and assistance with activities of daily living.

(I) Duplication of Services. 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 applicant or client regardless of whether the individual resides in a long term care facility or receives services within their home.

(II) “Advocating for services” shall not be an allowable service under a PCC.

(D) 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.

(E) The applicant or client shall submit detailed logs to clearly identify the services provided under the PCC. The logs shall include the date, time, amount paid, and services provided.

(F) 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.

(G) Caregivers receiving compensation under a PCC shall report compensation as income for tax purposes. Documentation of income reporting shall be provided to the Department upon request.

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

(f) Patient Contribution.

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

(ii) Allowable deductions shall be applied in accordance with the Social Security Act, 42 C.F.R. Chapter IV, Subchapter C, Part 435, Subpart I and the Medicaid State Plan.

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

(A) The deduction is not allowed when a physician verifies the client will not be able to return to the home within six (6) months; and

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

(iv) Deductions for a community spouse who lives in the community when the married partner lives in a medical institution, receives services under a Home & Community Based Services Waiver, or Hospice Care, shall be applied in the manner prescribed in Title XIX of the Social Security Act, 42 C.F.R. Chapter IV, Subchapter. C, Part 435, Subpart I and the Medicaid State Plan.

(g) Benefits. Benefits begin:

(i) After completion of thirty (30) consecutive days in a medical institution or thirty (30) days after a hospice election. Benefits begin the first day of the month of entry into the medical institution when all eligibility requirements are met.

(ii) Home and Community Based Services begin on the first day of the month during which the plan of care is approved by the Department.

(h) Transfer penalties are imposed as follows:

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

(A) Fair Market Value means an estimate of the value of a resource if sold at the prevailing price at the time it was actually transferred.

(I) When determining the value of real property, fair market value shall be based on an appraisal or market analysis of the resource at the time of the sale or transfer of the property. The applicant or recipient has the obligation to provide the Department with an appraisal or market analysis. Failure to provide the requested documentation shall result in a denial of eligibility in accordance with Section 4(c)(iii) of this Chapter.

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

(1.) A transfer to a relative for care provided for free in the past is a transfer for less than fair market value. An individual can rebut this presumption with tangible evidence that is acceptable to the Department. Such evidence shall be in writing at the time services were provided to be considered by the Department.

(ii) A transfer penalty shall be reduced in the amount of returned resources to the applicant or recipient. The amount of returned resources shall be determined using Fair Market Value, as defined in (h) of this Section.

(A) A return of resources to pay for attorney fees during a contested case shall not reduce the penalty period for the applicant or recipient. Attorney fees are the sole responsibility of the contestant under Chapter 4.

(iii) Undue hardship, as specified in Section 1917(c) of the Social Security Act, shall apply to transfer of resource penalties. Any request for an undue hardship shall be made in writing and include documentation to support and demonstrate an undue hardship in accordance with this Section.

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

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

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

(1.) "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 the individual's current or former spouse.

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

(B) Undue hardship will be considered if the transfer penalty would deprive the individual of food, clothing, shelter, or other necessities of life or medical care such that the individual's health or life would be endangered and one of the following has occurred:

(I) It is determined that the receiving party 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 receiving party 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.

(1.) “Exhausting all reasonable legal means to recover” may include seeking the advice of an attorney and pursuing legal or equitable remedies, such as asset freezing, assignment, or injunction; seeking modification, avoidance, or nullification of a financial instrument, promissory note, mortgage, or other transfer agreement; cooperating with any attempt to recover the transferred asset; making a referral to Adult Protective Services; filing a police report; and seeking recovery through the court.

(C) Undue hardship does not exist when:

(I) The applicant or client transferred the resource in order to qualify for Medicaid;

(II) The imposition of the transfer penalty is only an inconvenience or may restrict the applicant’s lifestyle;

(III) The undoing of a transfer would cause adverse tax consequences, interest charges, or other contract damages;

(IV) The undoing of a transfer would cause hardship to an individual who is not the applicant or client; or

(V) The applicant or client does not meet the criteria as set forth in Subsection (B).

(i) Reporting Changes. Clients shall be responsible for reporting to the Department any changes in the following:

(i) Income;

(ii) Resources;

(iii) Household size;

(iv) Health insurance; and

(v) Address.

Section 9. Special Eligibility Group.

(a) Breast and Cervical Cancer Treatment Program.

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

(b) Treatment of Income.

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

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

(c) Age Requirement. Individuals shall be under the age of 65.

(d) Not eligible for Medicaid and has no health insurance.

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

(f) Reporting Changes. Clients shall be responsible for reporting to the Department any changes in the following:

- (i) Income;
- (ii) Health insurance;
- (iii) Address; and
- (iv) Conclusion of treatment.

Section 10. Employed Individuals with Disabilities Eligibility Group.

(a) Medicaid benefits are available to individuals with disabilities who work and pay a monthly premium for their healthcare coverage as specified in Section 1902(a)(10)(A)(ii)(XV) of the Social Security Act and 42 U.S.C. § 1396a(a)(10).

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

(c) Treatment of Resources. Resource tests do not apply for this eligibility group.

(d) Age Requirement. Individuals shall be age sixteen (16) through sixty-four (64).

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

(f) Premium. The individual shall pay a monthly premium, as calculated according to Wyoming Statutes §§ 42-4-115 and 42-4-116.

(g) Reporting Changes. Clients shall be responsible for reporting to the Department any changes in the following:

- (i) Income;
- (ii) Household size;
- (iii) Health insurance; and
- (iv) Address.

Section 11. Medicare Savings Programs.

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

- (i) Individuals shall be entitled to Medicare.
- (ii) Treatment of Income. Countable income shall be equal to or less than one hundred percent (100%) of the Federal Poverty Level (FPL).
- (iii) Treatment of Resources. Countable resources shall not exceed three (3) times the SSI resource limit, as adjusted annually by the increase in the consumer price index.
- (iv) Benefits begin the first day of the following month after eligibility is determined.

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

- (i) Individuals shall be entitled to Medicare.
- (ii) Treatment of Income. Countable income shall be more than one hundred percent (100%) of the FPL but less than or equal to one hundred twenty percent (120%) of the FPL.
- (iii) Treatment of Resources. Countable resources shall not exceed three (3) times the SSI resource limit, as adjusted annually by the increase in the consumer price index.

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

(i) Individuals shall be entitled to Medicare

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

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

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

(e) **Reporting Changes.** Clients shall be responsible for reporting to the Department any changes in the following:

(i) Income;

(ii) Resources;

(iii) Household size;

(iv) Health insurance; and

(v) Address.

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

Section 13. Delegation of Duties. The Department may delegate any of its duties under this rule to the Wyoming Attorney General, HHS, 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.

Section 14. Interpretation of Chapter.

(a) The order in which the provisions of this Chapter appear is not to be construed to mean that any one provision is more or less important than any other provision.

(b) The text of this Chapter shall control the titles of its various provisions.

Section 15. Superseding effect. This Chapter supersedes all prior rules or policy statements issued by the Department, including manuals and bulletins, which are inconsistent with this Chapter.

Section 16. Severability. If any portion of these rules is found invalid or unenforceable, the remainder shall continue in effect.

Section 17. Incorporation by Reference.

(a) For any code, standard, rule, or regulation incorporated by reference in these rules:

(i) The Department has determined that incorporation of the full text in these rules would be cumbersome or inefficient given the length or nature of the rules;

(ii) The incorporation by reference does not include any later amendments or editions of the incorporated matter beyond the applicable date identified in subsection (b) of this section; and

(iii) The incorporated code, standard, rule, or regulation is maintained at the Department and is available for public inspection and copying at cost at the same location.

(b) Each rule or regulation incorporated by reference in these rules is further identified as follows:

(i) Referenced in Sections 4, 5, 6, and 7 of this Chapter is 42 C.F.R., Chapter IV, Subchapter C, Part 435, incorporated as of the effective date of this Chapter and can be found at <http://www.ecfr.gov>.

(ii) Referenced in Sections 4 and 8 of this Chapter is the Wyoming Medicaid State Plan, incorporated as of the effective date of this Chapter and can be found at <https://health.wyo.gov/healthcarefin/medicaid/spa/>.

(iii) Referenced in Sections 5 and 11 of this Chapter is 42 C.F.R. Chapter IV, Subchapter C, Part 440, incorporated as of the effective date of this Chapter and can be found at <http://www.ecfr.gov>.

(iv) Referenced in Sections 6 and 7 of this Chapter is 42 C.F.R. Chapter IV, Subchapter C, Part 433, incorporated as of the effective date of this Chapter and can be found at <http://www.ecfr.gov>.

(v) Referenced in Section 7 and 8 of this Chapter is 20 C.F.R. Chapter III, Part 416, incorporated as of the effective date of this Chapter and can be found at <http://www.ecfr.gov>.

(vi) Referenced in Section 4, 6, 7, 8, 9, 10, and 11 of this Chapter is Title XIX of the Social Security Act—Grants to States for Medical Assistance Programs, incorporated as of the effective date of this Chapter and can be found at <http://ssa.gov>.

(vii) Referenced in Section 6 of this Chapter is 42 U.S.C. § 1382a, incorporated as of the effective date of this Chapter and can be found at <http://ssa.gov>.

(viii) Referenced in Section 7 of this Chapter is 42 U.S.C. § 1382c, incorporated as of the effective date of this Chapter and can be found at <http://ssa.gov>.

(ix) Referenced in Section 6 of this Chapter is Section 1115A of the Social Security Act, incorporated as of the effective date of this Chapter and can be found at <http://ssa.gov>.

(x) Referenced in Section 7 of this Chapter is Section 1634 of the Social Security Act, incorporated as of the effective date of this Chapter and can be found at <http://ssa.gov>.

(xi) Referenced in Section 7 is 42 U.S.C. § 1396p, incorporated as of the effective date of this Chapter and can be found at <http://ssa.gov>.