16.5 CATEGORICALLY NEEDY, MANDATORY - FOR FAMILIES AND/OR CHILDREN

NOTE: No Categorically Needy coverage group is subject to a spenddown provision.

A. AFDC MEDICAID RECIPIENTS (MAAR, MAAU)

Income: 185% Need Standard (1993 FPL) Assets: $1,000
100% Need Standard (1993 FPL)
Payment Level (24% 1994 FPL)

Refer to Chapter 15 for a complete explanation of AFDC Medicaid.

AFDC Medicaid provides for Medicaid coverage for those who would be eligible for AFDC, if the Program were still in effect, including those who would not have received a check because they were eligible for under $10. Therefore, the eligibility determination process is the same as it was for the former Program, except that the check amount determined at the end of the process is not issued to the client. It is merely used to determine if the client would be eligible to receive an assistance check from the former Program. If so, AFDC Medicaid is approved; if not, eligibility under all other Medicaid coverage groups must be explored.

NOTE: Receipt of a WV WORKS check has no bearing on Medicaid eligibility. Receipt of a WV WORKS check does not automatically qualify the client to receive Medicaid.

B. DEEMED AFDC RECIPIENTS

The following coverage groups are required by law to be treated as AFDC recipients for Medicaid purposes. This treatment automatically qualifies them for AFDC Medicaid. Therefore, the information in item A, above, is also applicable to these cases.

1. Extended Medicaid (ME C, ME S)

Income: N/A Assets: N/A

A family is eligible for Extended Medicaid when both of the following conditions are met:

- The family lost eligibility for AFDC Medicaid due to receipt of or an increase in child or spousal support; and

- The family received AFDC Medicaid in any 3 or more months during the 6-month period that immediately precedes the first month of ineligibility for AFDC Medicaid.

2. Children Covered Under Title IV-E Adoption Assistance
Income: N/A Assets: N/A

Families which receive Title IV-E Adoption Assistance payments from West Virginia for an adopted child, receive a medical card for the child only. This is provided by Social Services and is produced by the SSIS system. The Income Maintenance staff has no responsibilities in providing this coverage.

However, when a child receives Title IV-E Adoption Assistance and is also an SSI recipient, the Worker must determine which coverage group is appropriate for the child, as follows:

- When the child receives Title IV-E Adoption Assistance from West Virginia, medical coverage is provided as a recipient of Title IV-E Adoption Assistance. The Worker must not provide medical coverage for the child as an SSI recipient.

- When the child receives Title IV-E Adoption Assistance from a state other than West Virginia, coverage is provided in West Virginia as an SSI Recipient. See Section 16.6,A.

3. Children Covered Under Title IV-E Foster Care

Income: N/A Assets: N/A

Persons who receive Title IV-E Foster Care payments from West Virginia for a foster child, receive a medical card for the foster child only. This is provided by Social Services and is produced by the SSIS system. The Income Maintenance staff has no responsibilities in providing this coverage.

However, when a child receives Title IV-E Foster Care and is also an SSI recipient, the Worker must determine which coverage group is appropriate for the child, as follows:

- When the child receives Title IV-E Foster Care from West Virginia, medical coverage is provided as a recipient of Title IV-E Foster Care. The Worker must not provide medical coverage for the child as an SSI recipient.

- When the child receives Title IV-E Foster Care from a state other than West Virginia, coverage is provided in West Virginia as an SSI Recipient. See Section 16.6,A.

C. TRANSITIONAL MEDICAID (TM) (ME I, ME T, ME D)

Income: Phase I - N/A **Assets: N/A**
Phase II - 185% FPL

NOTE: TM is not related in any way to DCA eligibility or the loss of WV WORKS eligibility. DCA eligibility or ineligibility for WV WORKS, regardless of the reason, does not qualify the family for TM. TM eligibility is concerned only with ineligibility for AFDC Medicaid.

This coverage group consists of families which lose eligibility for AFDC Medicaid because of earned income, the loss of earned income disregards or the number of hours worked. Transitional Medicaid (TM) provides continuing medical coverage after AFDC Medicaid eligibility ends and is provided in two (2) phases as described below.

There are no application procedures for Transitional Medicaid Instead, when an AFDC Medicaid case becomes ineligible, the Worker must automatically determine eligibility for TM. If the case is closed in error instead of being converted to a TM case, the case must be reopened without reapplication by the client.

1. Phase I Coverage

a. Eligibility Requirements

In order to be eligible for Phase I coverage, all of the following conditions must be met:

- The benefit group became ineligible for AFDC Medicaid due to hours of employment, amount of income from employment or from loss of the AFDC/U time-limited earned income disregards ($30 + 1/3 or $30 disregard).*

NOTE: In determining ineligibility for AFDC Medicaid, the Worker must consider income of the benefit group and any individual who would normally be included in the benefit group, but who has been penalized.

- The benefit group received AFDC Medicaid in any 3 or more months during the 6-month period immediately preceding the first month of ineligibility for AFDC Medicaid.

  NOTE: Receipt of WV WORKS or a DCA payment does not meet this requirement. It is met only by receipt of AFDC Medicaid for at least 3 of the last 6 months.

- There is no indication that the benefit group received AFDC Medicaid fraudulently during any of the 6 months prior to the first month of AFDC Medicaid ineligibility.

- The family has a dependent child who would be included in the AFDC Medicaid benefit group, if the family were eligible.

* When the benefit group becomes ineligible for AFDC Medicaid for a combination of reasons, the Worker must determine if the amount of earned income, hours worked or loss of time-limited disregards (or the addition of an individual with earnings who has received AFDC Medicaid in 3 of the past 6 months), had an effect on the ineligibility. Only when this is the case is the benefit group eligible for TM.

* The following steps are followed to determine if such factors had an effect on ineligibility for AFDC Medicaid:

* Step 1: Determine if the increase in income (or hours of employment or loss of the AFDC/U earned income disregards) would have resulted in loss of AFDC Medicaid if all other factors in the case remained the same (i.e., there was no other change in income, no change in family composition, no change in AFDC Medicaid standards, etc.).

* If yes, the benefit group meets the requirement.

* If no, go to Step 2.

* Step 2: Determine if events other than the increase in income (or hours of employment or loss of the AFDC/U earned income disregards) would have resulted in loss of AFDC Medicaid if the income (hours or disregards) had stayed the same.

* If yes, the benefit group does not meet the requirement.

* If no, go to Step 3.

* Step 3: Determine if the family is ineligible for AFDC Medicaid when all changes are considered.

* If yes, the benefit group meets the requirement. The increase in earnings (or hours of employment or loss of the AFDC/U earned income disregards) was essential to the loss of AFDC Medicaid eligibility. Without that increase, the family would not have lost eligibility.

* If no, the family is still eligible for AFDC Medicaid.

b. Loss of Eligibility Before Expiration of Full Phase I Coverage

The following circumstances will result in case closure (after proper notice) before the expiration of the Phase I coverage:

(1) No Dependent Child

When there is no child in the home who would be eligible for AFDC Medicaid, the benefit group loses eligibility. Eligibility ends at the end of the first month in which the family no longer includes such a child.

EXAMPLE: Last dependent child leaves the home on February 10. The case is closed effective February. Advance notice is required.

(2) Fraud

When it is determined that AFDC Medicaid benefits received in one or more of the 6 months prior to the start of Phase I coverage were received fraudulently, the benefit group is ineligible. Eligibility ends on the last day of the month when the advance notice period expires.

(3) Enrollment in Free Employer's Plan

When the person whose employment caused ineligibility for AFDC Medicaid does not enroll or maintain enrollment in the employer's health plan, provided such coverage is free to the client, the benefit group becomes ineligible. Eligibility ends on the last day of the month when the advance notice period expires. Benefits are not delayed pending compliance with this requirement. The client must be allowed 30 days to prove he has taken the steps necessary to comply.

NOTE: There is no provision to discontinue Phase I coverage for failure of the parent to continue working.

NOTE: Failure, without good cause, to return a complete PR L3 by the due date results in ineligibility to participate in Phase II of TM, but has no effect on Phase I coverage.

c. Eligible Situations

Provided the benefit group meets all of the eligibility requirements in item a above, it is eligible for Phase I TM in the following situations:

- The benefit group's gross income is above 185% or 100% of the AFDC/U Standard of Need or the countable income is above the payment level, and the beginning of employment or increase in hours or payment rate had an effect on AFDC Medicaid ineligibility.

- The earned income of an individual who received AFDC Medicaid in 3 of the last 6 months and who is added to the benefit group, has an effect on the benefit group's AFDC Medicaid ineligibility.

- The case becomes ineligible for AFDC Medicaid due to failure to report or provide verification of new earnings, provided that fraud is not indicated.

- The case becomes ineligible for 1 month only due to a temporary increase in hours worked or rate of pay.

d. Ineligible Situations

The benefit group is not eligible for Phase I coverage in the following situations:

- The benefit group becomes ineligible because of the earnings of an individual being added to the benefit group who has not received AFDC Medicaid in 3 of the last 6 months.

- The benefit group becomes ineligible for a reason other than those found in item 1,a above.

- There is an indication, with supporting evidence, that the benefit group received AFDC Medicaid fraudulently during at least 1 of the 6 months prior to the first month of AFDC Medicaid ineligibility. The Worker must determine from the case record if a referral has been made to IFM or if an IFM decision has been rendered on any fraud claim. If there is a substantive indication that fraud was involved, the family is not eligible for Phase I coverage.

NOTE: There is no provision to discontinue Phase I coverage for failure of the parent to continue working.

NOTE: There is no provision to discontinue Phase I coverage due to the benefit group's becoming eligible for AFDC Medicaid again. Instead, the benefit group is dually eligible for AFDC Medicaid and TM. See item 3 below for the significance of dual eligibility.

e. Beginning Date of Phase I Coverage

A benefit group is eligible for Phase I coverage beginning the month following the last month of AFDC Medicaid eligibility. When AFDC Medicaid is continued beyond the month ineligibility occurs because of an agency or client error, the beginning date of TM is the first month for which the client should have lost eligibility, taking into consideration advance notice requirements.

f. Client's Reporting Requirements

The client is required to report his gross earnings and day care costs for the first 3 months of Phase I coverage by the 21st of the fourth month. He is also required to report the earnings and day care costs of any person in the home who is included in the AFDC Medicaid Income Group. In addition, he must report his gross earnings and day care costs for the last 3 months of Phase I coverage by the 21st of the first month of Phase II coverage.

A RAPIDS letter (PR L3) is mailed to the client on the first day of the fourth and sixth months.

If the client returns both completed PR L3 forms, he has met one of the eligibility requirements for Phase II coverage.

Failure to return a completed form, without good cause, by the 21st of the fourth month, automatically renders the family ineligible to participate in Phase II, after proper notice. The client must be notified of the consequences of his actions when the form is not returned by the 21st without good cause or is returned but

is incomplete. The client has a right to a Fair Hearing on this issue since future eligibility is involved. The Worker must not wait until the end of Phase I coverage to notify the client of his ineligibility for Phase II. The process of determining eligibility or ineligibility, based on this reporting requirement, is completed prior to the end of Phase I coverage.

The PR L3 must be filed in the case record.

The good cause determination is made by the Worker and Supervisor and must be based on reasonable expectations; these generally will involve situations over which the client has little control.

A RAPIDS alert notifies the Worker when the form is due.

If the client provides the completed form within the 13-day notice period, this part of the eligibility requirement for Phase II is reestablished.

g. Special Agency Notification Requirements

During the 4th and 6th months of Phase I eligibility, the client is notified of the availability of Phase II coverage and what he must do to continue coverage.

2. Phase II Coverage

NOTE: When all eligibility factors for Phase II coverage are met, eligibility continues, without interruption, from Phase I to Phase II, unless the client has indicated he does not wish to continue such coverage.

a. Eligibility Requirements

In order to be eligible for Phase II coverage, all of the following conditions must be met:

- The benefit group received Phase I coverage for the entire 6-month Phase I period. The 6-month period includes months for which the client was dually eligible for Phase I and AFDC Medicaid, if applicable.

- The client completed and returned, in a timely manner, all PR L3's sent to him, or had good cause for not returning them. The form is considered to be returned in a timely manner when it is received within the advance notice period.

- The family has a dependent child who would be eligible for AFDC Medicaid.

- The earned income amount meets the financial test as described in Chapter 10. For the first 3 months of Phase II coverage, information from the first PR L3 is used. For the second 3 months of Phase II coverage, information from the second PR L3 is used.

- The client continues to have earnings, unless the lack of earnings is due to involuntary loss of employment, illness, or unless good cause is established.

- The client applies for and maintains enrollment in his employer's health plan, provided such coverage is free to the client.

b. Beginning Date of Phase II Coverage

A benefit group is eligible for Phase II coverage beginning the first month immediately after Phase I coverage ends. When Phase II coverage is, in error, not begun in the correct month, coverage begins upon discovery of the error and is backdated to the date coverage should have begun. In no instance is Phase II coverage extended beyond 6 months past the end of Phase I coverage.

c. Client's Reporting Requirements

The client is required to report his gross earnings, the gross earnings of other Income Group adults in the home, and actual out-of-pocket day care costs for the first 3 months of Phase II coverage. This information is used to determine financial eligibility for the remainder of the Phase II period. The PR L3 is mailed at the end of the 3rd month and must be

completed and returned by the 21st of the fourth month, unless the client establishes good cause.

The good cause determination is made by the Worker and Supervisor and must be based on reasonable expectations; these generally will involve situations over which the client has little control.

The PR L3 must be filed in the case record. A RAPIDS alert notifies the Worker that the form is due.

d. Automatic Termination of TM

The data system will automatically terminate TM eligibility at the end of Phase II coverage and alert the Worker to test for eligibility under all other coverage groups.

When TM eligibility ends for any reason other than expiration of the time period, the Worker must stop the benefit and consider eligibility under all other coverage groups.

3. Return to AFDC Medicaid, Phases I and II

If a benefit group returns to AFDC Medicaid during Phase I or Phase II, but otherwise meets the requirements for TM, the benefit group is dually eligible for AFDC Medicaid and TM. If the benefit group again becomes ineligible for AFDC Medicaid, Worker action depends upon the case circumstances at the time of the subsequent case closure as follows.

a. Otherwise Eligible for TM

If the benefit group meets all of the eligibility requirements found in item 1,a above, the family is eligible for a new TM period, beginning with Phase I for 6 months and continuing through Phase II, if the Phase II requirements are met.

b. Not Otherwise Eligible for TM

When either of the two following conditions are met at the time of the subsequent case closure, the family is eligible only for the remainder of the original TM period.

- The benefit group loses eligibility for a reason not related to employment; or

- The benefit group loses eligibility for a reason related to employment, but does not meet the requirement of having received AFDC Medicaid in 3 of the preceding 6 months.

  EXAMPLE: An AFDC Medicaid benefit group becomes ineligible when the parent obtains full-time employment. The family receives TM for 7 months, from March through September, but returns to AFDC Medicaid for 2 months, October and November. At the time the parent's job starts again, at the end of November, he has no longer received AFDC Medicaid in 3 of the 6 months prior to ineligibility. One of the eligibility requirements for TM is no longer met. However, because the benefit group was dually eligible for TM and AFDC Medicaid, TM coverage continues for December, January and February.

D. QUALIFIED CHILDREN (QC) BORN ON OR AFTER 10-1-83 (MQCA)

NOTE: For Qualified Children born before 10/1/83, see Section 16.7,E.

Income: 100% FPL **Assets: N/A**

NOTE: If a Qualified Child is receiving inpatient services on the date eligibility ends due to attainment of the maximum age limit, eligibility must continue until the end of that inpatient stay.

A child is eligible for Medicaid coverage as a Qualified Child (QC) when all of the following conditions are met:

- The child is not eligible for SSI Medicaid

- The child was born on or after 10-1-83.

- The child is under age 19, regardless of school attendance or course completion date.

- The income eligibility requirements described in Chapter 10 are met.

QC's are not required to have an AFDC/U deprivation factor or to live with a specified relative. There is no asset test fo such children.

The maximum allowable age for children under this coverage group increases each year due to the requirement that these children be born on or after 10-1-83. The maximum ages and dates they become effective are as follows:

Year	Maximum Age
10/95	12
10/96	13
10/97	14
10/98	15
10/99	16
10/00	17
10/01	18
10/02	19 - Eligibility ends at age 19

When a QC becomes pregnant, refer to item E,3,c below for mor information.

E. POVERTY-LEVEL PREGNANT WOMAN

A pregnant woman is eligible for Medicaid coverage as a Poverty-Level Pregnant Woman or as a Deemed Poverty-Level Pregnant Woman as follows. In certain situations, eligibilit may be backdated more than 3 months. See Chapter 1.

1. Categorically Needy, Deemed Poverty-Level Pregnant Woman

Income: N/A **Assets: N/A**

Any woman who is pregnant when she is an eligible Categorically Needy, Medicaid recipient, remains eligible for Medicaid throughout her pregnancy and through a 60-day postpartum period when both of the following conditions are met:

- The woman receives Medicaid under any mandatory or optional Categorically Needy coverage group. See Sections 16.5, 16.6 and 16.7. Those women who apply for such coverage groups after the birth of the child, are not eligible as Categorically Needy, Deemed Poverty-Level Pregnant Women, but may be eligible as a Poverty-Level Pregnant Woman. See item 3 below.

- The pregnant woman becomes ineligible for the Categorically Needy coverage group due solely to a change in income.

The pregnant woman's coverage must continue under the same Categorically Needy coverage group through the end of the postpartum coverage.

If the pregnant woman does not meet these requirements, the requirements in item 3 below must be met to continue eligibility based solely on her pregnancy.

2. Medically Needy, Deemed Poverty-Level Pregnant Woman

Income: N/A Assets: N/A

Any woman who is pregnant when she is an eligible Medically Needy recipient, remains eligible for Medicaid through the end of the current Period of Eligibility (POE), when both of the following conditions are met:

- The woman has no spenddown or the spenddown has been met.

- The woman must met another spenddown within the same Period of Consideration (POC) due solely to a change in income.

At the end of the original POE, the pregnant woman's eligibility ends and reapplication is required. Eligibility is determined as for any other Medically Needy case, with pregnancy having no effect on eligibility. If the spenddown is met in the new POC, or it is met and another spenddown must be met due solely to a change in income, the pregnant woman is again guaranteed medical coverage only until the end of the POE. Only when the Medically Needy pregnant woman gives birth to the child during a Medically

Needy POE, is she guaranteed medical coverage through the 60-day postpartum period.

If the pregnant woman does not meet these requirements, the requirements in item 3 below must be met to continue eligibility based solely on her pregnancy.

3. Poverty-Level Pregnant Woman (MFPP)

Income: 150% FPL Assets: N/A

a. General Requirements

A pregnant woman is eligible for Medicaid coverage as a Poverty-Level Pregnant Woman when all of the following conditions are met:

- The pregnant woman is not receiving:

  " AFDC Medicaid
  " SSI

  and is not eligible as a Deemed AFDC Recipient or a Deemed Poverty-Level Pregnant Woman.

- The income eligibility requirements described in Chapter 10 are met. Changes in income after eligibility has been established have no effect on continuing eligibility.

Poverty-level pregnant women are <u>not</u> required to have a <u>deprivation factor</u> and there is <u>no asset test.</u>

b. Postpartum Coverage

A woman continues to be eligible for Medicaid for 60 days postpartum, and the remaining days of the month in which the 60th day falls, provided that during the pregnancy or within 3 months of the end of the pregnancy, the woman met all of the following requirements:

- She applied for Medicaid (any coverage group)

- She was eligible for Medicaid (any coverage group)

- She received Medicaid services (any covered service, not limited to pregnancy services).

If the mother is determined, after the end of the pregnancy, to have been eligible in a month prior to the end of the pregnancy, she is eligible for postpartum coverage. This is true even if income increases above the income eligibility limits in any month after she is determined eligible.

The last day of pregnancy is counted as day one of the 60-day postpartum period.

This coverage applies only to the mother, not the child. The child may be covered as a Continuously Eligible Newborn. Refer to item I below.

NOTE: Postpartum coverage is required if the pregnancy ends in a live birth, miscarriage, abortion, or if the child is stillborn.

F. POVERTY-LEVEL CHILDREN UNDER AGE 1 (MFPI)

Income: 150% FPL **Assets: N/A**

NOTE: If a child is receiving inpatient services on the date he would lose eligibility due to attainment of age one (1), eligibility must continue until the end of that inpatient stay.

NOTE: Twelve months of continuous Medicaid eligibility applies. See Section 2.8.

A child under the age of 1 is eligible for Medicaid coverage as a Poverty-Level Child Under Age 1 when all of the following conditions are met:

- The child is not eligible for SSI Medicaid

- The income eligibility requirements described in Chapter 10 are met.

A Poverty-Level Child Under Age 1 must not be required to have an AFDC/U deprivation factor or to live with a specified relative. There is no asset test for such children.

G. POVERTY-LEVEL CHILDREN, AGES 1-5 (MFPC)

Income: 133% FPL **Assets: N/A**

NOTE: If a child is receiving inpatient services on the date he would lose eligibility due to attainment of age 6, eligibility must continue until the end of that inpatient stay.

NOTE: Twelve months of continuous Medicaid eligibility applies. See Section 2.8.

A child at least age 1, but not yet age 6, is eligible as Poverty-Level Child Ages 1-5 when all of the following conditions are met:

- The child is not eligible for SSI Medicaid

- The income eligibility requirements described in Chapter 10 are met.

  Poverty-Level Children Ages 1-5 must not be required to have an AFDC/U deprivation factor or to live with a specified relative. There is no asset test for such children.

H. POVERTY-LEVEL CHILDREN, AGES 6-18 (BORN ON OR AFTER 10-1-83) (MFPN)

Income: 100% FPL **Assets: N/A**

NOTE: If a child is receiving inpatient services on the date he would lose eligibility due to attainment of the maximum age, eligibility must continue until the end of that inpatien stay.

NOTE: Twelve months of continuous Medicaid eligibility applies. See Section 2.8.

A child at least age 6, but not yet age 19 is eligible as a Poverty-Level Child, Ages 6-18, when all of the following conditions are met:

- The child is not eligible for SSI Medicaid
- The child was born on or after 10-1-83.
- The child is under age 19, regardless of school attendance or course completion date.
- The income eligibility requirements described in Chapter 10 are met.

A Poverty-Level Child, Age 6-18, must not be required to have an AFDC/U deprivation factor or to live with a specified relative. There is no asset test for such children.

The maximum allowable age for children under this coverage group increases each year due to the requirement that these children be born on or after October 1, 1983. The maximum ages and dates they become effective are as follows:

YEAR	MAXIMUM AGE
10/95	12
10/96	13
10/97	14
10/98	15
10/99	16
10/00	17
10/01	18
10/02	19 - Eligibility ends at age 19

I. CATEGORICALLY NEEDY (MN) CONTINUOUSLY ELIGIBLE NEWBORN CHILDREN (CEN),

NOTE: See Section 16.8,A for Medically Needy CEN coverage.

Income: N/A **Assets: N/A**

NOTE: If a child is receiving inpatient services on the date he would lose eligibility due to attainment of age 1, eligibility must continue until the end of that inpatient stay.

A Continuously Eligible Newborn Child (CEN) (birth - 12 months) is eligible for Medicaid until he reaches age 1, when all of the following conditions are met:

- The child is not eligible for SSI Medicaid

- A Medicaid application was made, or considered to have been made, and approved. The application may be made up to 3 months after the child's birth. If the child's mother was eligible for and receiving Medicaid in the month the child was born, an application is considered to have been made for the child.

- The child resides continuously in the mother's household. The definition of "resides with" or "lives with" which is used by the most closely

associated program (AFDC Medicaid or SSI) is used to meet this requirement.

NOTE: Under SSI, a child born to an institutionalized woman is eligible on the date of birth only. Eligibility under all other Medicaid coverage groups must be explored immediately for these children.

- The mother remains eligible for any Categorically Needy Medicaid coverage group or would be eligible for Categorically Needy Medicaid if she were still pregnant. Changes in the mother's family income never affect the child's eligibility as a CEN, because changes in income never affect the eligibility of a Poverty-Level Pregnant Woman. Refer to item E above. In addition, failure of the child's mother to complete a redetermination does not result in ineligibility for the CEN.

CEN's must not be required to have an AFDC/U deprivation factor or to live with a specified relative (other than the mother), and there is no income or asset test for such children. Enumeration requirements are not to be applied.

NOTE: There is no requirement that the CEN be evaluated as a QC. He must remain a CEN until he reaches age 1, as long as all CEN eligibility requirements are met.