The Department has chosen the option of providing Medicaid to disabled children, up to the age of 18, who can receive necessary medical services while residing in their family (natural or adoptive) homes or communities. The medical services must be more cost-effective for the State than placement in a medical institution such as a nursing home, ICF/MR facility, acute care hospital or approved Medicaid psychiatric facility for children under the age of 21.

This coverage group allows children to remain with their families by providing medical services in the home or community that are more cost-effective than care in a medical institution. It also eliminates the requirement that the income and assets of parents and/or legal guardians be deemed to the children.

A child is eligible for Medicaid as a CDCS client when all of the following conditions are met:

- The child has not attained the age of 18.

- The child's own gross income does not exceed 300% SSI payment level.

- The child has been determined to require a level of care provided in a medical institution, nursing home, ICF/MR, hospital or psychiatric facility.

- He is expected to receive the necessary services at home or in the community.

- The estimated cost of services is no greater than the estimated cost of institutionalization.

- The child would be eligible for an SSI payment if in a medical institution.

- The child has been denied SSI eligibility because the income and assets of his parent(s) were deemed to him, and, as a result, the SSI income or asset eligibility test was not met.

NOTE: At age 18, individuals must apply for SSI. If SSI eligible, they receive SSI Medicaid and no longer receive coverage as a CDCS recipient. Individuals who reach age 18 continue to receive the services until approved for SSI. No individual who has attained age 18 is to be approved.

NOTE: The Worker must refer the family to SSA to apply for SSI, if the family has not done so already, even though the Worker may be able to determine that SSA would deny the child as a result of deeming the parents' income and/or assets.

The Worker must then obtain a copy of the SSI denial letter and retain it in the case record.

The Long Term Care Unit in the Bureau for Medical Services determines medical eligibility and notifies the county office and the case management agency of the decision in writing. Refer to Chapter 12 for details about determining medical eligibility.

E. QUALIFIED CHILDREN BORN BEFORE 10-1-83 (QC-MEDICAID EXPANSION) (MQCB)

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 inpatient stay.

Beginning 7-1-94, the Department provides Medicaid to Qualified Children (Section 16.5,D), born prior to the federal eligibility date of 10-1-83. This was mandated by the State Legislature and required a waiver from federal regulations to implement. These children are Qualified Children in every way except their age. They are referred to as Medicaid Expansion cases, because the approved waiver allowed the Department to expand Qualified Child Medicaid coverage to more children.

All of the information in Section 16.5,D applies to these Medicaid Expansion cases except as follows:

- The child must have been born prior to 10-1-83.

- Coverage to age 19 is not phased in. Therefore, as the maximum age of Qualified Children born on or after 10-1-83 increases, the coverage group for Qualified Children born prior to 10-1-83 will be phased out.

NOTE: This coverage will be completely phased out on 9-30-02.

F. AIDS DRUG ASSISTANCE PROGRAM (ADAP)

Income: 325% FPL **Assets: N/A**

The **ADAP** is also **referred to** as the AIDS **Special Pharmacy** Program or **the** ADAP **WV Special Pharmacy Program.**

An individual is eligible for limited* Medicaid coverage when all of the following conditions are met:

- The individual must have been diagnosed as HIV positive.

- The income of the individual, his spouse and his dependent children who live with him must meet the **income** limits detailed in Chapter 10.

- He must be ineligible for any other Medicaid **full-**coverage group or be eligible as a Medically Needy client who has not met his spenddown.

* Medicaid coverage is limited to payment for **medications listed on the current WV ADAP Formulary** for **HIV/**AIDS **treatment.**

Except for acceptance of the initial **OFS-2 Medicaid and the 2-page ADAP applications,** this coverage group is administered by BMS. **Potential eligibility for or receipt of Medicare, Part D, does not affect the application or referral process for ADAP eligibility determination.** For special communication between the Worker and BMS, refer to Chapter 1.

If the client becomes eligible under any other coverage group or meets his spenddown, the Worker must notify BMS immediately by memorandum and must specify the beginning date of Medicaid eligibility.

G. WV CHILDREN'S HEALTH INSURANCE PROGRAM (WV CHIP)

WV CHIP is not Medicaid. See Chapter 7 for WV CHIP policy.

H. WOMEN WITH BREAST OR CERVICAL CANCER (BCC)

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

A woman is eligible for BCCSP Medicaid if she is diagnosed with a breast or cervical cancer or certain pre-cancerous conditions, regardless of income. She must also be receiving active treatment for her diagnosis and currently enrolled in the Breast and Cervical Cancer Screening Program through a screening provider to be eligible for this type of Medicaid coverage.

A woman who meets the following requirements may be eligible for full-coverage Medicaid:

- She has been diagnosed with breast or cervical cancer through the Centers for Disease Control (CDC) program administered by the Office of Maternal, Child and Family Health.

- She has no medical insurance or insurance that meets an exception listed in Chapter 7, Appendix A under Excepted Insurance Benefits. No penalty applies for discontinuing insurance.

- There may be limited situations in which a woman with creditable coverage can receive BCC coverage. Examples include, but are not limited to, no coverage for breast or cervical cancer, periods of exclusion, such as for a preexisting condition, or having exhausted lifetime or annual benefits for all services or for breast or cervical cancer.

- She is under age 65.

- She is not eligible for Medicaid under any of the following Mandatory Categorically Needy coverage groups:

  - AFDC Medicaid

  - Deemed AFDC Medicaid