16.7 CATEGORICALLY NEEDY, OPTIONAL

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

A. INDIVIDUALS RECEIVING HOME AND COMMUNITY BASED SERVICES UNDER TITLE XIX WAIVERS (MALH, MALM)

Income: 300% SSI Payment Level **Assets: $2,000**

The Department has elected to provide Medicaid to individuals who would be eligible for Medicaid if institutionalized and who would require institutionalization were it not for the availability of home and community-based services. To qualify, an individual may be elderly/disabled or mentally retarded/ developmentally disabled. Cost effectiveness plays a role in eligibility.

Details about the HCB Waiver (elderly/disabled) and the MR/DD Waiver (mentally retarded/developmentally disabled) are found in Chapter 17.

B. ADOPTION ASSISTANCE OTHER THAN IV-E

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

Special-needs children under age 21 who have State adoption assistance agreements (other than those under Title IV-E) in effect and who cannot be placed for adoption without Medicaid coverage are eligible for Medicaid.

This coverage group is the responsibility of Social Services and the medical card is produced by the FACTS system. The Income Maintenance staff has no responsibilities related to this coverage group.

C. FOSTER CARE OTHER THAN IV-E

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

Persons who receive foster care payments through the Department, but from a funding source other than Title IV-E, receive a medical card for the foster child only. This is provided by Social Services and is produced by the FACTS system. The Income Maintenance staff has no responsibilities related to this coverage group.

D. CHILDREN WITH DISABILITIES COMMUNITY SERVICE PROGRAM (CDCS) (MALC)

Income: 300% SSI Payment Level **Assets: $2,000**

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 **or are age 19, whichever occurs first.** No individual who has attained age 18 is 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 **local** office and the case management agency of the decision in writing. Refer to Chapter 12 for details about determining medical eligibility.

NOTE: When an applicant's eligibility for, or enrollment in, this program is pending, he must not be refused the right to apply due to his pending status with the CDCS Program, but must be evaluated for any or all DFA programs.

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.

Recipients are screened for eligibility for other mandatory Medicaid coverage groups, and, if found eligible, are approved for the other group. Failure to apply for Medicaid or to assist in the eligibility determination process results in case closure.

NOTE: Eligibility for any optional coverage group does not apply, and there is no spenddown provision.

2. Application Process

The application process is as follows:

- A woman is screened at a Breast and Cervical Cancer Screening Program site. If diagnosed with breast or cervical cancer, she is given a CDC Certificate of Diagnosis and completes form DFA-BCC-1.

- The DFA-BCC-1 form is forwarded by the CDC facility to the DHHR office in the county in which the applicant resides. The Worker enters the information in RAPIDS to issue a medical card, provided all eligibility criteria described above are met.

- If information provided on the DFA-BCC-1 indicates that the woman is not income or asset eligible for any other mandatory Medicaid coverage group, no action is taken, but the decision must be recorded in RAPIDS.

- If the information indicates the woman may be eligible under one of the mandatory coverage groups listed in item 1 above, the Worker contacts the woman, arranges for an interview, and requests any additional information required to determine eligibility.

- If the woman is determined Medicaid eligible for a mandatory coverage group, the Worker closes the BCC AG and approves the new coverage group.

- If ineligible for a mandatory Medicaid coverage group, the woman remains in the BCC group and the Worker records the results of the determination process in RAPIDS.

- If the woman or a representative fails to apply within 30 days, or she fails to cooperate in determining eligibility for a mandatory Medicaid coverage group, the BCC case is closed.

NOTE: BCC recipients are not required to cooperate with BCSE unless they become eligible for another mandatory coverage group. Women who would be eligible for another mandatory group, except for failure to cooperate with BCSE, are not eligible for BCC.

3. Redetermination Process

An annual redetermination for BCC and Medicaid eligibility is required. OMCFH is responsible for providing a BCC Medicaid Continuation Form to verify continuing treatment and for assuring that a new completed DFA-BCC-1 is mailed to the local DHHR office.

If changes have occurred which indicate the woman may be eligible for one of the Medicaid groups listed **in item 1** above, the Worker must schedule an interview to complete a Medicaid application. The BCC case remains open while the determination is being made. Failure to complete or cooperate in the Medicaid application process will result in closure of the BCC case.

If determined eligible for a **mandatory** Medicaid group, the Worker closes the BCC coverage and takes action to approve the woman for the appropriate Medicaid coverage group. **See item 1 above for mandatory coverage groups.**

If it appears there have been no significant changes and the woman continues to meet all other BCC requirements, no action is taken in RAPIDS. The Worker files the forms in the case record and makes appropriate cases comments.

4. Data System Coding and Communications with the Breast and Cervical Cancer Program (BCCSP)

To insure that needed services are not delayed after approval for BCC and that BCCSP has current information about individuals who are closed or denied, the Worker must follow the procedures outlined below:

- Follow RAPIDS instructions for coding BCC using PRD-38

- Print the ACCH screen, which must include the BCC applicant's name