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, **intellectually**/ developmentally disabled, or have a traumatic brain injury. Cost effectiveness plays a role in eligibility.

Details about the HCB Waiver (elderly/disabled), **I**/DD Waiver **intellectual/developmental disability**) and TBI Waiver (Traumatic Brain Injury) 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**

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 must be completed in the following order:

- 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 Eligibility Requirements above, the Worker contacts the woman, arranges for an application to be completed, and requests any additional information required to determine eligibility. No interview is required. See Chapter 1 for specific Medicaid coverage group interview requirements.

- 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 Eligibility Requirements above, the Worker must contact her 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 Eligibility Requirements 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 case 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 current address screen, which must include the BCC applicant's name