

16.3 MEDICAID ELIGIBILITY BETWEEN COVERAGE GROUPS

The Worker must consider all of the following information in determining eligibility and in establishing eligible cases.

A. CONSIDERATION OF ALL MEDICAID COVERAGE GROUPS

The client cannot be expected to know which Medicaid coverage group to apply for. When the client expresses an interest in applying for Medicaid, the Worker **MUST EXPLORE ELIGIBILITY FOR ALL MEDICAID COVERAGE GROUPS**. This does not mean that applications for all coverage groups must be taken and processed. It means that Medicaid eligibility cannot be denied until the client has been considered for each coverage group and that, if the client is eligible under more than one coverage group, he is approved for the one that will provide him with the most benefits in the fastest time frame.

Certain programs, such as CDCS, I/DD, TBI and HCB Waiver, require a medical and/or other determination by a community agency or government division other than DFA and a financial determination by **the Department**. When an applicant's medical eligibility for, or enrollment in, these programs is pending, he must not be refused the right to apply, but must be evaluated for any or all DFA programs.

Even if the client does not request an eligibility determination for Medicaid, the Worker must explain its availability if he believes the family could benefit from it. **IN NO INSTANCE IS MEDICAID COVERAGE UNDER ONE COVERAGE GROUP TO BE STOPPED WITHOUT CONSIDERATION OF MEDICAID ELIGIBILITY UNDER ALL OTHER COVERAGE GROUPS**. This is done before the client is notified that his Medicaid eligibility will end. Eligibility is determined based on case record information. The Worker may be required to contact the client for completion of a Social Summary for MRT.

See Section 2.11 for special procedures for SSI Medicaid when an individual is determined no longer disabled by SSA.

B. CONSIDERATION OF MAGI AND NON-MAGI COVERAGE GROUPS

Applicants who have income below the MAGI standard and determined eligible for coverage in a MAGI coverage group (the Adult Group, Parents/Caretaker Relatives, Pregnant Women, Children Under Age 19 group or WV CHIP) should be promptly enrolled into the MAGI coverage group. The client may also pursue eligibility for non-MAGI Medicaid coverage groups while enrolled in the MAGI group.

Specific Medicaid Requirements

Clients who are determined to meet the eligibility requirements for coverage in both a MAGI category and a non-MAGI category at application may choose to enroll in the non-MAGI category.

The Department must request all additional information needed to evaluate the client's potential eligibility for a non-MAGI group when the client:

- requests such a determination
- submits the application developed for non-MAGI coverage groups
- indicates potential eligibility on the single-streamlined application or renewal form, or
- if the Department otherwise has information indicating such potential eligibility. For example, a referral for CDCS, I/DD, TBI or HCB Waiver from a community agency.

Eligible for Non-MAGI Group

If the client is determined eligible for a non-MAGI coverage group they are enrolled into this coverage group and the MAGI group is closed.

Ineligible for Non-MAGI Group

If the client is ineligible for a non-MAGI coverage group, or a determination cannot be made because all necessary information was not provided, the client remains enrolled in the MAGI coverage group. The client is not required to provide any additional information needed to make a full eligibility determination for the non-MAGI coverage group.

Notification:

Information regarding potential eligibility for non-MAGI coverage groups and the benefits and services afforded to the applicant in the non-MAGI coverage groups will be provided to the applicant in the MAGI notice. Information regarding additional information needed to determine eligibility and how to apply will be provided to the applicant. The information should be sufficient to enable the applicant to make an informed choice.

When the applicant is determined ineligible for Medicaid or WV CHIP their electronic account will be transferred to the Marketplace for a determination of eligibility for Advanced Premium Tax Credits (APTC) or Cost-Sharing Reductions (CSR). See Section 1.24,G.

Specific Medicaid Requirements

MAGI Coverage Groups	Non-MAGI Coverage Groups
Adult Group	SSI
Parents/Caretaker	Deemed SSI
Pregnant Women Group	<ul style="list-style-type: none"> ○ Disabled Adult Children ○ Substantial Gainful Activity ○ Essential Spouses ○ Pass-Throughs ○ Pickle Amendment Coverage ○ Disabled Widows and Widowers ○ Drug Addicts and Alcoholics
Children Under Age 19 Group	
WV CHIP	
	Continuously Eligible Newborn
	Transitional Medicaid
	Extended Medicaid
	Adoption and Foster Care Medicaid
	SSI-Related (spenddown)
	AFDC-Related (spenddown)
	M-WIN
	Breast and Cervical Cancer (BCC)
	Medicaid Premium Assistance
	<ul style="list-style-type: none"> ○ Qualified Medicare Beneficiary ○ Specified Low-Income Beneficiary ○ Qualified Individual ○ Qualified Disabled Working Individuals
	Nursing Home
	Home & Community Based Waiver
	Intellectual Disability and Developmental Disabilities (I/DD)
	Intermediate Care Facility/Mentally Retarded (ICF/MR)
	Traumatic Brain Injury Waiver (TBI)
	Children with Disabilities Community Service Program (CDCSP)
	Illegal Alien Emergency Medical
	Refugee Medical Assistance
	Special Pharmacy
	AIDS Drug Assistance Program

Specific Medicaid Requirements

C. WHO RECEIVES LIMITED COVERAGE

All Medicaid coverage groups receive the full services the State offers to its Medicaid recipients except the following coverage groups: QMB, SLIMB, QI-1, Illegal Aliens, **Special Pharmacy**, AIDS Programs and QDWI. The limitations are described in Sections 16.5 - 16.11. In addition, any coverage group's services can be limited when a penalty for an uncompensated transfer of resources is applied. Refer to Chapter 17 to determine when to apply such a penalty and to the RAPIDS User Guide to accomplish the limitation.

D. BACKDATING MEDICAID COVERAGE

Unless specifically stated under the appropriate coverage group, Medicaid coverage may be backdated for up to 3 months prior to the month of application, provided all eligibility requirements were met at that time and provided the client has unpaid medical expenses.