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**

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. 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 DFA-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. The resource development policies in Chapter 5 do not apply to ADAP. 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.

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

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

G. 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.

1. Eligibility Requirements

   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 coverage groups:

  - Parents/Caretaker Relatives
  - Adult Group
  - Transitional Medicaid
  - Children Under Age 19
  - Pregnant Woman
  - SSI Medicaid
  - Deemed SSI Medicaid

Medicaid eligibility begins up to three months prior to the month of application, providing she would have met the eligibility criteria, and concludes when the cancer treatment ends or when she is no longer eligible. For example, she attains age 65 or obtains creditable insurance. Coverage is not limited to charges related only to cancer treatment, and there is no limit to the number of eligibility periods for which a woman may qualify.

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 **e**RAPIDS to issue a medical card, provided all eligibility criteria described in Eligibility Requirements 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 **e**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 **e**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 **e**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 **e**RAPIDS instructions for coding BCC using PRD-38

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

- Write the status of the case on the bottom of the printout. Examples include, but are not limited to, approved for BCC, needs CDC certificate or ineligible for BCC as eligible for another mandatory coverage group.

- Fax the printout, along with the CDC certificate of diagnosis and the BCC Medicaid application, to the attention of: BCCSP at (304) 558-7164 or mail to the Office of Maternal, Child and Family Health (OMCFH), ATTN: BCCSP, 350 Capitol Street, Room 427, Charleston, WV 25301-3715.

Notify BCC by fax or mail of any change in the BCC client's name, demographic change or death.

H. SSI-RELATED/NON-CASH ASSISTANCE (MS Reason Code 193)

Income: SSI Payment Level **Assets: $2,000 Individual**
$3,000 Couple

NOTE: This Categorically Needy, Optional coverage group is not subject to the spenddown provision.

Individuals who meet the SSI definition of aged, blind or disabled are eligible for Medicaid when all of the following conditions are met. Aged means 65 years or over. All requirements in Chapter 12 for determining disability or blindness for SSI-Related coverage groups apply to this coverage group.

- Countable income is under the SSI Maximum Payment level, see chapter 10, Appendix A. The income eligibility determination methodology detailed in Chapter 10.23 applies to this coverage group. Refer to the SSI-Related column in the chart of income sources in Chapter 10.3 for this coverage group.

- Countable assets do not exceed the limits for the SSI-Related program described in Chapter 11. All SSI-Related asset methodologies found in Chapter 11 apply to this coverage group. Refer to the SSI groups column in the list of assets in Chapter 11.4 for this coverage group.

I. AFDC/NON-CASH ASSISTANCE

Income: 185% Need Standard **Assets: $1,000**
100% Need Standard
AFDC Payment Level

Note: This Categorically Needy, Optional coverage group is not subject to the spenddown provision.

Caretaker Relatives and pregnant women are eligible for Medicaid under this coverage group when all of the following conditions are met. Eligibility determination groups are determined according to AFDC methods detailed in Chapter 9.4

- Countable income is under the AFDC Payment level. The income eligibility determination methodology detailed in Chapter 10.7 applies to this coverage group.

- Countable assets do not exceed the limits for the AFDC program described in Chapter 11. All AFDC asset methodologies found in Chapter 11 apply to this coverage group.

- The individual is otherwise eligible for AFDC Medicaid. For the purpose of this Section only, otherwise eligible means the AG includes a dependent child, living with a specified relative and a deprivation factor exists.