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, MALC, MALD)

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 AD Waiver (Aged/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**

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 receiving Medicare benefits.

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

  - Parents/Caretaker Relatives
  - Adult Group
  - Transitional Medicaid
  - Extended 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 eRAPIDS 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 eRAPIDS.

- 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 eRAPIDS.

- 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.