



## 2. Children Covered Under Title IV-E Adoption Assistance

**Income: N/A**

**Assets: N/A**

Families which receive Title IV-E Adoption Assistance payments from West Virginia for an adopted child, receive a medical card for the child only. This is provided by Social Services and is produced by the SSIS system. The Income Maintenance staff has no responsibilities in providing this coverage.

However, when a child receives Title IV-E Adoption Assistance and is also an SSI recipient, the Worker must determine which coverage group is appropriate for the child, as follows:

- When the child receives Title IV-E Adoption Assistance from West Virginia, medical coverage is provided as a recipient of Title IV-E Adoption Assistance. The Worker must not provide medical coverage for the child as an SSI recipient.
- When the child receives Title IV-E Adoption Assistance from a state other than West Virginia, coverage is provided in West Virginia as an SSI Recipient. See Section 16.6,A.

## 3. Children Covered Under Title IV-E Foster Care

**Income: N/A**

**Assets: N/A**

Persons who receive Title IV-E Foster Care payments from West Virginia for a foster child, receive a medical card for the foster child only. This is provided by Social Services and is produced by the SSIS system. The Income Maintenance staff has no responsibilities in providing this coverage.

However, when a child receives Title IV-E Foster Care and is also an SSI recipient, the Worker must determine which coverage group is appropriate for the child, as follows:

- When the child receives Title IV-E Foster Care from West Virginia, medical coverage is provided as a recipient of Title IV-E Foster Care. The Worker must not provide medical coverage for the child as an SSI recipient.



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**NOTE:** In determining ineligibility for AFDC Medicaid, the Worker must consider income of the AG and any individual who would normally be included in the AG, but who has been penalized.

- The AG received AFDC Medicaid in any 3 or more months during the 6-month period immediately preceding the 1<sup>st</sup> month of ineligibility for AFDC Medicaid.

**NOTE:** Receipt of WV WORKS or a DCA payment does not meet this requirement. It is met only by receipt of AFDC Medicaid for at least 3 of the last 6 months.

- The AG did not receive AFDC Medicaid fraudulently during any of the 6 months prior to the 1<sup>st</sup> month of AFDC Medicaid ineligibility.
  - The family has a dependent child who would be included in the AFDC Medicaid AG, if the family were eligible.
- \* When the AG becomes ineligible for AFDC Medicaid for a combination of reasons, the Worker must determine if the amount of earned income, hours worked or loss of time-limited disregards (or the addition of an individual with earnings who has received AFDC Medicaid in 3 of the past 6 months), had an effect on the ineligibility. Only when this is the case is the AG eligible for TM.
  - \* The steps below are to be followed to determine if such factors had an effect on ineligibility for AFDC Medicaid:
    - \* Step 1: Determine if the increase in income (or hours of employment or loss of the AFDC/U earned income disregards) would have resulted in loss of AFDC Medicaid if all other factors in the case remained the same (i.e., there was no other change in income, no change in family composition, no change in AFDC Medicaid standards, etc.).
      - \* If yes, the AG meets the requirement.
      - \* If no, go to Step 2.
    - \* Step 2: Determine if events other than the increase in income (or hours of employment or loss of the

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AFDC/U earned income disregards) would have resulted in loss of AFDC Medicaid if the income (hours or disregards) had stayed the same.

- \* If yes, the AG does not meet the requirement.
- \* If no, go to Step 3.
- \* Step 3: Determine if the AG is ineligible for AFDC Medicaid when all changes are considered.
- \* If yes, the AG meets the requirement. The increase in earnings (or hours of employment or loss of the AFDC/U earned income disregards) was essential to the loss of AFDC Medicaid eligibility. Without that increase, the AG would not have lost eligibility.
- \* If no, the AG is still eligible for AFDC Medicaid.

b. Loss of Eligibility Before Expiration of Full Phase I Coverage

The following circumstances will result in case closure (after proper notice) before the expiration of the Phase I coverage:

(1) No Dependent Child

When there is no child in the home who would be eligible for AFDC Medicaid, the AG loses eligibility. Eligibility ends at the end of the 1<sup>st</sup> month in which the AG no longer includes such a child.

**EXAMPLE:** Last dependent child leaves the home on February 10<sup>th</sup>. The case is closed effective February. Advance notice is required.

(2) Fraud

When it is determined that AFDC Medicaid benefits received in one or more of the 6 months prior to the start of Phase I coverage were received fraudulently, the AG is ineligible. Eligibility ends on the last day of the month when the advance notice period expires.

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## (3) Enrollment in Free Employer's Plan

When the person whose employment caused ineligibility for AFDC Medicaid does not enroll or maintain enrollment in the employer's health plan, provided such coverage is free to the client, the AG becomes ineligible. Eligibility ends on the last day of the month when the advance notice period expires. Benefits are not delayed pending compliance with this requirement. The client must be allowed 30 days to prove he has taken the steps necessary to comply.

**NOTE:** There is no provision to discontinue Phase I coverage for failure of the parent to continue working.

**NOTE:** Failure, without good cause, to return a complete PRL3 by 1<sup>st</sup> work day after the 20th of the 4th month results in ineligibility to participate in Phase II of TM, but has no effect on Phase I coverage.

## c. Eligible Situations

Provided the AG meets all of the eligibility requirements in item a above, it is eligible for Phase I TM in the following situations:

- The AG's gross income is above 185% or 100% of the AFDC/U Standard of Need or the countable income is above the payment level, and the beginning of employment or increase in hours or payment rate had an effect on AFDC Medicaid ineligibility.
- The earned income of an individual who received AFDC Medicaid in 3 of the last 6 months and who is added to the AG, has an effect on the AG's AFDC Medicaid ineligibility.
- The case becomes ineligible for AFDC Medicaid due to failure to report or provide verification of new earnings, provided that fraud is not indicated.
- The case becomes ineligible for 1 month only due to a temporary increase in hours worked or rate of pay.

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## d. Ineligible Situations

The AG is not eligible for Phase I coverage in the following situations:

- The AG becomes ineligible because of the earnings of an individual being added to the AG who has not received AFDC Medicaid in 3 of the last 6 months.
- The AG becomes ineligible for a reason other than those found in item 1,a above.
- There is an indication, with supporting evidence, that the AG received AFDC Medicaid fraudulently during at least 1 of the 6 months prior to the first month of AFDC Medicaid ineligibility. The Worker must determine from the case record if a referral has been made to IFM or if an IFM decision has been rendered on any fraud claim. If there is a substantive indication that fraud was involved, the AG is not eligible for Phase I coverage.

**NOTE:** There is no provision to discontinue Phase I coverage for failure of the parent to continue working.

**NOTE:** There is no provision to discontinue Phase I coverage due to the AG's becoming eligible for AFDC Medicaid again. Instead, the AG is dually eligible for AFDC Medicaid and TM. See item 3 below for the significance of dual eligibility.

## e. Beginning Date of Phase I Coverage

An AG is eligible for Phase I coverage beginning the month following the last month of AFDC Medicaid eligibility. When AFDC Medicaid is continued beyond the month ineligibility occurs because of an agency or client error, the beginning date of TM is the 1<sup>st</sup> month for which the client should have lost eligibility, taking into consideration advance notice requirements.

## f. Client's Reporting Requirements

The client is required to report his gross earnings and day care costs for the first 3 months of Phase I coverage by the 1<sup>st</sup> work day after the 20<sup>th</sup> of the 4<sup>th</sup> month. He is also required to report

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the earnings and day care costs of any person in the home who is included in the AFDC Medicaid Income Group. In addition, he must report his gross earnings and day care costs for the last 3 months of Phase I coverage by the 1<sup>st</sup> work day after the 20<sup>th</sup> of the 1<sup>st</sup> month of Phase II coverage.

RAPIDS letter PRL3, is mailed to the client by the 3<sup>rd</sup> Friday of the 3<sup>rd</sup> month.

If the client returns the completed PRL3 form, he has met one of the eligibility requirements for Phase II coverage.

Failure to return a completed form, without good cause, by the 1<sup>st</sup> work day after the 20<sup>th</sup> of the 4<sup>th</sup> month, automatically renders the AG ineligible to participate in Phase II, after proper notice. The client must be notified of the consequences of his actions when the form is not returned by the due date without good cause or is returned but is incomplete. The client has a right to a Fair Hearing on this issue since future eligibility is involved. The Worker must not wait until the end of Phase I coverage to notify the client of his ineligibility for Phase II. The process of determining eligibility or ineligibility, based on this reporting requirement, is completed prior to the end of Phase I coverage.

The PRL3 must be filed in the case record.

The good cause determination is made by the Worker and Supervisor and must be based on reasonable expectations; these generally will involve situations over which the client has little control.

A RAPIDS alert notifies the Worker when the form is due.

If the client provides the completed form within the 13-day notice period, this part of the eligibility requirement for Phase II is reestablished.

g. **Special Agency Notification Requirements**

During the 4th month of Phase I eligibility, the client is notified of the availability of Phase II coverage and what he must do to continue coverage.

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## 2. Phase II Coverage

**NOTE:** When all eligibility factors for Phase II coverage are met, eligibility continues, without interruption, from Phase I to Phase II, unless the client has indicated he does not wish to continue such coverage.

## a. Eligibility Requirements

In order to be eligible for Phase II coverage, all of the following conditions must be met:

- The AG received Phase I coverage for the entire 6-month Phase I period. The 6-month period includes months for which the client was dually eligible for Phase I and AFDC Medicaid, if applicable.
- The client completed and returned, in a timely manner, the PRL3 sent to him, or had good cause for not returning it. The form is considered to be returned in a timely manner when it is received within the advance notice period.
- The family has a dependent child who would be eligible for AFDC Medicaid.
- The earned income amount meets the financial test as described in Chapter 10. For Phase II coverage, information from the PRL3 is used. Information from the PRL3 determines eligibility for months 7 – 12 of Phase II TM coverage. Information from the PRL8 determines continued eligibility for months 9 – 12 of Phase II and the PRL9 determines eligibility for month 12 of TM.
- The client continues to have earnings, unless the lack of earnings is due to involuntary loss of employment, illness, or unless good cause is established.
- The client applies for and maintains enrollment in his employer's health plan, provided such coverage is free to the client

## b. Beginning Date of Phase II Coverage

An AG is eligible for Phase II coverage beginning the 1<sup>st</sup> month immediately after Phase I coverage ends. When Phase II coverage

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is, in error, not begun in the correct month, coverage begins upon discovery of the error and is backdated to the date coverage should have begun. In no instance is Phase II coverage extended beyond 6 months past the end of Phase I coverage.

c. Client's Reporting Requirements

The client is required to report his gross earnings, the gross earnings of other Income Group adults in the home, and actual out-of-pocket day care costs. This information is used to determine financial eligibility for Phase II coverage. The PRL3 is mailed by the 3<sup>rd</sup> Friday of the 3<sup>rd</sup> month and must be completed and returned by the 1<sup>st</sup> work day after the 20<sup>th</sup> of the 4<sup>th</sup> month, unless the client establishes good cause.

The PRL8 is mailed by the 3<sup>rd</sup> Friday of the 6<sup>th</sup> month and the completed form is due by the 1<sup>st</sup> work day after the 20<sup>th</sup> of the 7<sup>th</sup> month. The PRL9 is mailed by the 3<sup>rd</sup> Friday of the 9<sup>th</sup> month and the completed form is due by the 1<sup>st</sup> work day after the 20<sup>th</sup> of the 10<sup>th</sup> month. All PRL forms must be returned by the due date, unless the client establishes good cause.

The good cause determination is made by the Worker and Supervisor and must be based on reasonable expectations; these generally will involve situations over which the client has little control.

The PRL forms must be filed in the case record. A RAPIDS alert notifies the Worker that the forms are due.

d. Automatic Termination of TM

The data system will automatically terminate TM eligibility at the end of 8<sup>th</sup> month if the PRL8 is not returned by the due date.

RAPIDS will automatically terminate TM at the end of the 11<sup>th</sup> month if the PRL9 is not returned by the due date.

At the end of the TM Phase II, the data system will automatically terminate coverage.

**NOTE:** When TM eligibility ends for any reason other than expiration of the time period, the Worker must evaluate eligibility of the AG for all other Medicaid coverage groups.

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## 3. Return To AFDC Medicaid, Phases I and II

If an AG returns to AFDC Medicaid during Phase I or Phase II, but otherwise meets the requirements for TM, the AG is dually eligible for AFDC Medicaid and TM. If the AG again becomes ineligible for AFDC Medicaid, Worker action depends upon the case circumstances at the time of the subsequent case closure as follows.

## a. Otherwise Eligible for TM

If the AG meets all of the eligibility requirements found in item 1,a above, the family is eligible for a new TM period, beginning with Phase I for 6 months and continuing through Phase II, if the Phase II requirements are met.

## b. Not Otherwise Eligible for TM

When either of the two following conditions are met at the time of the subsequent case closure, the AG is eligible only for the remainder of the original TM period.

- The AG loses eligibility for a reason not related to employment; or
- The AG loses eligibility for a reason related to employment, but does not meet the requirement of having received AFDC Medicaid in 3 of the preceding 6 months.

**EXAMPLE:** An AFDC Medicaid AG becomes ineligible when the parent obtains full-time employment. The family receives TM for 7 months, from March through September, but returns to AFDC Medicaid for 2 months, October and November. At the time the parent's job starts again, at the end of November, he has no longer received AFDC Medicaid in 3 of the 6 months prior to ineligibility. One of the eligibility requirements for TM is no longer met. However, because the AG was dually eligible for TM and AFDC Medicaid, TM coverage continues for December, January and February.

**D. QUALIFIED CHILDREN (QC) BORN ON OR AFTER 10-1-83 (MQCA)**

**NOTE:** For Qualified Children born before 10/1/83, see Section 16.7,E.

## Specific Medicaid Requirements

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

**NOTE:** If a Qualified Child is receiving inpatient services on the date eligibility ends due to attainment of the maximum age limit, eligibility must continue until the end of that inpatient stay.

A child is eligible for Medicaid coverage as a Qualified Child (QC) when all of the following conditions are met:

- The child is not eligible for SSI Medicaid
- The child was born on or after 10-1-83.
- The child is under age 19, regardless of school attendance or course completion date.
- The income eligibility requirements described in Chapter 10 are met.

QC's are not required to have an AFDC/U deprivation factor or to live with a specified relative. There is no asset test for such children.

**E. POVERTY-LEVEL PREGNANT WOMAN**

A pregnant woman is eligible for Medicaid coverage as a Poverty-Level Pregnant Woman or as a Deemed Poverty-Level Pregnant Woman as follows. In certain situations, eligibility may be backdated more than 3 months. See Chapter 1.

**1. Categorically Needy, Deemed Poverty-Level Pregnant Woman****Income: N/A****Assets: N/A**

Any woman who is pregnant when she is an eligible Categorically Needy, Medicaid recipient, remains eligible for Medicaid throughout her pregnancy and through a 60-day postpartum period when both of the following conditions are met:

- The woman receives Medicaid under any mandatory or optional Categorically Needy coverage group. See Sections 16.5, 16.6 and 16.7. Those women who apply for such coverage groups after the birth of the child, are not eligible as Categorically Needy, Deemed Poverty-Level Pregnant Women, but may be eligible as a Poverty-Level Pregnant Woman. See item 3 below.

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- The pregnant woman becomes ineligible for the Categorically Needy coverage group due solely to a change in income.

The pregnant woman's coverage must continue under the same Categorically Needy coverage group through the end of the postpartum coverage.

If the pregnant woman does not meet these requirements, the requirements in item 3 below must be met to continue eligibility based solely on her pregnancy.

## 2. Medically Needy, Deemed Poverty-Level Pregnant Woman

**Income: N/A**

**Assets: N/A**

Any woman who is pregnant when she is an eligible Medically Needy recipient, remains eligible for Medicaid through the end of the current Period of Eligibility (POE), when the woman has no spenddown or the spenddown has been met.

At the end of the original POE, the pregnant woman's eligibility ends and reapplication is required. Eligibility is determined as for any other Medically Needy case, with pregnancy having no effect on eligibility. If the spenddown is met in the new POC, or it is met and another spenddown must be met due solely to a change in income, the pregnant woman is again guaranteed medical coverage only until the end of the POE. Only when the Medically Needy pregnant woman gives birth to the child during a Medically Needy POE, she is guaranteed medical coverage through the 60-day postpartum period.

If the pregnant woman does not meet these requirements, the requirements in item 3 below must be met to continue eligibility based solely on her pregnancy.

## 3. Poverty-Level Pregnant Woman (MFPP)

**Income: 150% FPL**

**Assets: N/A**

### a. General Requirements

A pregnant woman is eligible for Medicaid coverage as a Poverty-Level Pregnant Woman when all of the following conditions are met:

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- The pregnant woman is not receiving:
    - AFDC Medicaid
    - SSI
- and is not eligible as a Deemed AFDC Recipient or a Deemed Poverty-Level Pregnant Woman.
- The income eligibility requirements described in Chapter 10 are met. Changes in income after eligibility has been established have no effect on continuing eligibility.

Poverty-level pregnant women are not required to have a deprivation factor and there is no asset test.

**NOTE:** A Poverty-level pregnant woman is not referred nor required to cooperate with child support activities while pregnant nor during the post partum period.

b. Postpartum Coverage

This coverage applies only to the mother, not the child. The child may be covered as a Continuously Eligible Newborn. Refer to item I below.

A woman who received coverage as a pregnant woman while living in another state or who is a recipient of postpartum coverage from another state, is not eligible for postpartum coverage in WV, unless she is determined eligible for Poverty-Level Pregnant Woman coverage in WV.

A woman continues to be eligible for Medicaid for 60 days postpartum, and the remaining days of the month in which the 60th day falls, provided that during the pregnancy or within 3 months of the end of the pregnancy, the woman met all of the following requirements:

- She applied for Medicaid (any coverage group)
- She was eligible for Medicaid (any coverage group)
- She received Medicaid services (any covered service, not limited to pregnancy services).

## Specific Medicaid Requirements

If the mother is determined, after the end of the pregnancy, to have been eligible in a month prior to the end of the pregnancy, she is eligible for postpartum coverage. This is true even if income increases above the income eligibility limits in any month after she is determined eligible.

**NOTE:** Postpartum coverage is required if the pregnancy ends in a live birth, miscarriage, abortion, or if the child is stillborn.

The last day of pregnancy is counted as day one of the 60-day postpartum period, and a redetermination is completed in the 2<sup>nd</sup> month of the postpartum period. If eligible for other Medicaid, or WV CHIP, that coverage must not begin until expiration of the postpartum period.

If no review takes place, Medicaid coverage will automatically close after the adverse notice period.

#### F. POVERTY-LEVEL CHILDREN UNDER AGE 1 (MFPI)

**Income: 150% FPL**

**Assets: N/A**

**NOTE:** If a child is receiving inpatient services on the date he would lose eligibility due to attainment of age 1, eligibility must continue until the end of that inpatient stay.

**NOTE:** Twelve months of continuous Medicaid eligibility applies. See Section 2.8.

A child under the age of 1 is eligible for Medicaid coverage as a Poverty-Level Child Under Age 1 when all of the following conditions are met:

- The child is not eligible for SSI Medicaid
- The income eligibility requirements described in Chapter 10 are met.

A Poverty-Level Child Under Age 1 must not be required to have an AFDC/U deprivation factor or to live with a specified relative. There is no asset test for such children.

#### G. POVERTY-LEVEL CHILDREN, AGES 1-5 (MFPC)

**Income: 133% FPL**

**Assets: N/A**

## Specific Medicaid Requirements

**NOTE:** If a child is receiving inpatient services on the date he would lose eligibility due to attainment of age 6, eligibility must continue until the end of that inpatient stay.

**NOTE:** Twelve months of continuous Medicaid eligibility applies. See Section 2.8.

A child at least age 1, but not yet age 6, is eligible as Poverty-Level Child Ages 1-5 when all of the following conditions are met:

- The child is not eligible for SSI Medicaid
- The income eligibility requirements described in Chapter 10 are met.

Poverty-Level Children Ages 1-5 must not be required to have an AFDC/U deprivation factor or to live with a specified relative. There is no asset test for such children.

#### H. **POVERTY-LEVEL CHILDREN, AGES 6-18 (BORN ON OR AFTER 10-1-83) (MFPN)**

**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.

**NOTE:** Twelve months of continuous Medicaid eligibility applies. See Section 2.8.

A child at least age 6, but not yet age 19 is eligible as a Poverty-Level Child, Ages 6-18, when all of the following conditions are met:

- The child is not eligible for SSI Medicaid
- The child was born on or after 10-1-83.
- The child is under age 19, regardless of school attendance or course completion date.
- The income eligibility requirements described in Chapter 10 are met.

A Poverty-Level Child, Age 6-18, must not be required to have an AFDC/U deprivation factor or to live with a specified relative. There is no asset test for such children.

**I. CATEGORICALLY NEEDY (MN) CONTINUOUSLY ELIGIBLE NEWBORN CHILDREN (CEN),**

**NOTE:** See Section 16.8,A for Medically Needy CEN coverage.

**Income: N/A**

**Assets: N/A**

**NOTE:** If a child is receiving inpatient services on the date he would lose eligibility due to attainment of age 1, eligibility must continue until the end of that inpatient stay.

A Continuously Eligible Newborn Child (CEN) (birth - 12 months) is eligible for Medicaid until he reaches age 1, when all of the following conditions are met:

- The child is not eligible for SSI Medicaid
- A Medicaid application was made, or considered to have been made, and approved. The application may be made up to 3 months after the child's birth. If the child's mother was eligible for and receiving Medicaid from West Virginia in the month the child was born, an application is considered to have been made for the child.
- The child resides continuously in West Virginia during the entire CEN period. If the child leaves WV and returns, CEN coverage cannot be reinstated.

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**NOTE:** Under SSI, a child born to an institutionalized woman is eligible on the date of birth only. Eligibility under all other Medicaid coverage groups must be explored immediately for these children.

- The mother remains eligible for any Categorically Needy Medicaid coverage group or would be eligible for Categorically Needy Medicaid if she were still pregnant. Changes in the mother's family income never affect the child's eligibility as a CEN, because changes in income never affect the eligibility of a Poverty-Level Pregnant Woman. Refer to item E above. In addition, failure of the child's mother to complete a redetermination does not result in ineligibility for the CEN.

CEN's must not be required to have an AFDC/U deprivation factor or to live with a specified relative (other than the mother), and there is no income or asset test for such children. Enumeration requirements are not to be applied.

**NOTE:** There is no requirement that the CEN be evaluated as a QC. He must remain a CEN until he reaches age 1, as long as all CEN eligibility requirements are met.