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, 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 or mentally retarded/developmentally disabled. Cost effectiveness plays a role in eligibility.

Details about the HCB Waiver (elderly/disabled) and the MR/DD Waiver (mentally retarded/developmentally disabled) 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. No individual who has attained age 18 is to be 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 county office and the case management agency of the decision in writing. Refer to Chapter 12 for details about determining medical eligibility.

E. QUALIFIED CHILDREN BORN BEFORE 10-1-83 (QC-MEDICAID EXPANSION) (MQCB)

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.

Beginning 7-1-94, the Department provides Medicaid to Qualified Children (Section 16.5,D), born prior to the federal eligibility date of 10-1-83. This was mandated by the State Legislature and required a waiver from federal regulations to implement. These children are Qualified Children in every way except their age. They are referred to as Medicaid Expansion cases, because the approved waiver allowed the Department to expand Qualified Child Medicaid coverage to more children.

All of the information in Section 16.5,D applies to these Medicaid Expansion cases except as follows:

- The child must have been born prior to 10-1-83.

- Coverage to age 19 is not phased in. Therefore, as the maximum age of Qualified Children born on or after 10-1-83 increases, the coverage group for Qualified Children born prior to 10-1-83 will be phased out.

NOTE: This coverage will be completely phased out on 9-30-02.

F. AIDS PROGRAMS

Income: 250% FPL **Assets: N/A**

There are two (2) coverage groups which provide special services to individuals with AIDS. Medicaid coverage is limited for both groups as found below:

1. 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.
   - His family's income must meet the limits detailed in Chapter 10.
   - He must be ineligible for any other Medicaid coverage group or be eligible as a Medically Needy client who has not met his spenddown.

   * Medicaid coverage is limited to payment for AZT and any other FDA-approved drug treatment for AIDS.

   Except for acceptance of the initial application, this coverage group is administered by BMS. 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.

2. HIV Grant 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.
   - His own income must meet the limits detailed in Chapter 10.
   - His physician must document the medical necessity of the services for which the client is requesting help.

* Medicaid coverage is limited to in-home health/homemaker services, durable medical equipment and supplies, home IV therapy and home-administered diagnostic lab tests.

NOTE: Those people eligible for the Special Pharmacy Program (item 1, above) are eligible for services provided to this coverage group as soon as the medical necessity is established.

Except for acceptance of the initial application, this coverage group is administered by BMS. 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.

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

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

H. WOMEN WITH BREAST OR CERVICAL CANCER (BCC)

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

A woman who meets the following requirements may be eligible for full-coverage Medicaid:

S 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.

S She has no medical insurance or has only insurance that meets an exception listed in Chapter 7 under Excepted Insurance Benefits. No penalty applies for discontinuing insurance.

S She is under age 65.

S She is not eligible for Medicaid under any of the following Mandatory Categorically Needy coverage groups:

- AFDC Medicaid
- Deemed AFDC Medicaid
- Transitional Medicaid

- Qualified Child Medicaid
- Poverty-Level Pregnant Woman
- Poverty-Level Child
- 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.

The application process is as follows:

S 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 OFS-BCC-1.

S The OFS-BCC-1 form is then 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.

S If information provided on the OFS-BCCSP-02/2001 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.

S If it appears she may be eligible under one of the mandatory coverage groups listed above, the Worker contacts the woman, arranges for an interview, and requests any additional information required to determine eligibility.

S If the woman is determined Medicaid eligible for a mandatory coverage group, the Worker closes the BCC AG and approves the new coverage group.

NOTE: All redetermination and reporting requirements of the new coverage group apply, since the woman is no longer eligible for the BCC program.

S If not eligible 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.

S If she fails to apply or no one applies for her within 30 days, or she fails to cooperate in determining eligibility for mandatory Medicaid coverage groups, the BCC case is closed.

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 OF-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 above, the Worker must schedule an interview 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 another Medicaid group, the Worker closes the BCC coverage and takes action to approve the woman for the appropriate Medicaid coverage group.

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 cases comments.