Department of Human Resources 311 West Saratoga Street Baltimore MD 21201	**Family Investment Administration** **ACTION TRANSMITTAL**
Control Number: 08-32	**Effective Date: 7/1/2008** **Issuance Date: 5/5/2008**

TO: DIRECTORS, LOCAL DEPARTMENTS OF SOCIAL SERVICES
DEPUTY/ASSISTANT DIRECTORS FOR FAMILY INVESTMENT
FAMILY INVESTMENT SUPERVISORS AND ELIGIBILITY STAFF
HEALTH OFFICERS, LOCAL HEALTH DEPARTMENTS
LOCAL HEALTH DEPARTMENT ELIGIBILITY STAFF

FROM: KEVIN M. MCGUIRE, EXECUTIVE DIRECTOR, FIA
CHERYL A. CAMILLO, EXECUTIVE DIRECTOR, DHMH/OES

RE: MEDICAID EXPANSION

PROGRAM AFFECTED: MEDICAL ASSISTANCE

ORIGINATING OFFICE: OFFICE OF ELIGIBLITY SERVICES

SUMMARY

During the 2007 Legislative Special Session, Governor O'Malley proposed and the legislature passed Senate Bill 6 (SB 6), the Working Families and Small Business Health Coverage Act. SB 6 included a provision to expand Medicaid eligibility to low income families with dependent children with incomes up to 116% of the Federal poverty level. Currently, Medicaid covers parents/caretaker relatives and their children with incomes up to approximately 30% of the FPL. As a result of this expansion, many more parents and their children will be eligible for Medicaid.

DHMH and DHR are working to implement Medicaid Expansion, which requires systems modifications in CARES and MMIS. Additional policy clarification will be forthcoming as systems modifications are completed.

POLICY/PROCEDURAL CHANGES

The following policy changes will become effective July 1, 2008:

1. Verification of income will no longer be mandatory for the F-Track coverage groups. F-Track applicants/recipients will be permitted to self-declare their income;
2. Assets will be considered for the F98 and F99 coverage groups only; assets will **not** be considered for any other F-Track groups;
3. The face to face interview will no longer be mandatory, but may be required at the discretion of the case manager or at the request of the applicant/recipient;

4. 116% of the Federal Poverty Level will be the new effective standard for the F05, F98 and F99 coverage groups;
5. A new Medicaid application will be available for families, children and pregnant women;
6. In addition to the Local Departments of Social Services (LDSS), the Local Health Departments (LHDs) will take Medicaid applications for families applying for F-track coverage and will process those cases;
7. The LDSS and LHDs shall accept mail-in or **faxed** applications and signatures. (Electronic signatures are expected to be available in the Service Access Information Link (SAIL) system by 10/1/08.);
8. An application filed in a LHD with an associated case in a LDSS should be transferred to the LDSS via the Accelerated Certification of Eligibility (ACE) process. Information regarding ACE can be found in the MCHP manual;

The following policy changes will become effective August 25, 2008:

1. If Temporary Cash Assistance (TCA) is denied due to excess assets, the case will trickle to F05 in CARES and the applicant will be sent a denial notice for TCA and an approval notice for Medicaid (if the applicant is determined eligible in the F05 or another coverage group);
2. F05 will trickle to F02 for 12 months if F05 Medicaid is closed due to earned income when the family was receiving F01 and/or F05 for at least 3 of the previous 6 months;
3. F05 will trickle to F03 for 4 months if F05 Medicaid is closed due to excess child or spousal support income when the family was receiving F01 and/or F05 for at least 3 of the previous 6 months;
4. If F01 Medicaid is closed due to earned income; the case will trickle to F05. If earned income exceeds the income standard for F05 and the family was receiving F01 and/or F05 for at least 3 of the previous 6 months, the case will trickle to F02 for 12 months; and
5. If F01 Medicaid is closed due to excess child or spousal support income, the case will trickle to F05. If child or spousal support income exceeds the income standard for F05 and the family was receiving F01 and/or F05 for at least 3 of the previous 6 months, the case will trickle to F03 for 4 months.

THE NEW MEDICAID APPLICATION

1. The new Medicaid application will include:
    - Questions to identify absent/non-custodial parents; and
    - Information about verifying citizenship and identity (see AT 08-05).
2. The New application is to be used for an applicant applying at a LHD or LDSS for **Medicaid only** who is:

- A parent or a caretaker relative of a dependent child(ren);
- A child(ren); or
- A pregnant woman.

This application should <u>not be used</u> when an applicant is applying for ABD (Aged, Blind, or Disabled) PAC (Primary Adult Care), QMB (Qualified Medicare Beneficiary), SLMB (Specified Low Income Beneficiary), EID (Employed Individuals with Disabilities), 1915(c) Home and Community Based Services Waivers, TCA (Temporary Cash Assistance), FS (Food Stamps), TDAP (Temporary Disability Assistance Program), EAFC (Emergency Assistance for Families with Children), CS (Child Support), or EA (Energy Assistance).

APPLICATION PROCESS

General Application Procedures

1. Review application and materials for the following information:
    - That the applicant has completed all applicable portions of application;
    - That the applicant or representative has signed the application;
    - Verification of citizenship and identity;
    - Copy of health insurance card (front and back, if applicable); and
    - Verification of child care expenses, if applicable.
2. Perform the following clearances:
    - CARES (Client Automated Resources and Eligibility System);
    - CS (Child Support);
    - MABS (Maryland Automated Benefits System);
    - MMIS (Medicaid Management Information System);
    - SVES (State Verification Exchange System), SDX (State Data Exchange) and SOLQ (State On-Line Query); and
    - SAVE (Systematic Alien Verification for Entitlements).
3. Compare information received from clearances to information received from the applicant, then:
    - If a discrepancy exists or if information is questionable, request appropriate verification of that information;
    - Make a written request for any required documentation missing from the application;
    - Do not deny the application if a copy of the health insurance card has not been received but health insurance information has been provided; and
    - Do not deny the application if verification of child care expenses are not received, but do **not** allow the expense.

4. Use the valid value code OT (Other) instead of DS (Declaratory Statement) in order to prevent the case from closing due to no verification of income. Use this work-around until CARES programming changes are made.

LDSS – Specific Application Procedures

If an applicant has an associated case(s) in a LHD or in another LDSS, contact a clearinghouse worker, request a case transfer and perform the following procedures:

1. **For Family and Children Applicants:**
    - Pend the entire assistance unit (AU) in **F05**. Be sure to code any active P13 or P14 child as an AC (financial responsibility field) on the STAT screen, and determine eligibility;
    - If the **F05** AU is ineligible due to excess income, leave existing P-Track AUs open. The **F05** AU will trickle to F98, then F99, and then will sprout to any applicable P-Track coverage group. (See section regarding Spend-down Eligibility Procedures on page 8 of this AT.); or
    - If eligible as a **F05**, close any existing P-Track AUs with the exception of P13 and P14 AUs. (Use CARES code 507.)
2. **For a Pregnant Applicant with Dependent Children:**
    - Pend the entire AU in **F05**. Be sure to code any active P13 or P14 child as a AC (financial responsibility field) on the STAT screen, and determine eligibility;
    - If the **F05** AU is ineligible due to excess income, leave existing P-Track AUs open. The **F05** AU will first trickle to F98 and then to F99. The F99 will sprout to any applicable P-Track coverage group. (See section regarding Spend-down Eligibility Procedures on page 8 of this AT.); or
    - If eligible as a **F05**, close any existing P-Track AUs with the exception of P13 and P14 AUs. (Use CARES code 507.)
3. **For a Pregnant Applicant with No Dependent Children:**
    - Pend AU in P02 (not **F05)** and determine eligibility;
    - If P02 AU is ineligible due to excess income, it will trickle to P11; or
    - If the P11 AU is ineligible due to excess income, it will be denied by CARES.

If an applicant has no associated case(s) in a LHD or another LDSS

1. **For Family and Children Applicants:**
    - Pend the entire AU in **F05**, determine eligibility and finalize case.
    - If the **F05** AU is ineligible due to excess income, the **F05** AU will first trickle to F98 and then to F99. The F99 will sprout to any applicable

P-Track coverage group. (See section regarding Spend-down Eligibility Procedures on page 8 of this AT.); or

2. **For a Pregnant Applicant with Dependent Children:**

- Pend entire AU in **F05** and determine eligibility; or
- If the **F05** AU is ineligible due to excess income, the **F05** AU will first trickle to F98 and then to F99. The F99 will sprout to any applicable P-Track coverage group. (See section regarding Spend-down Eligibility Procedures on page 8 of this AT.)

For Pregnant Applicant with No Dependent Children:

- Pend AU in P02 (not **F05)** and determine eligibility;
- If P02 AU is ineligible due to excess income, it will trickle to P11; or
- If the P11 AU is ineligible due to excess income, it will be denied by CARES.

LHD – Specific Application Procedures

If an applicant has an associated case(s) in a LDSS

1. **For Family and Children Applicants:**

- Pend the entire AU in **F05** and determine eligibility using the ACE process for **F05** and P-Track coverage groups. Remember to consider income standards for both the **F05** and the applicable P-Track coverage groups when determining ACE eligibility. The ACE process has been modified to include the F05 and the new worksheet has a box to check if a member of the F05 unit is pregnant;
- If eligible, forward the case to the LDSS and send the new ACE form to DHMH's Division of Recipient Eligibility Programs (DREP) for processing; or
- If the **F05** AU is ineligible, leave any existing P-Track AUs open, transfer case electronically on CARES, and forward case record to LDSS for case completion.

2. **For a Pregnant Applicant with Dependent Children:**

- Pend the entire AU in **F05** and determine eligibility using the ACE process for **F05** and P-Track coverage groups. Remember to consider income standards for both the F05 and the applicable P-Track coverage groups when determining ACE eligibility. The ACE process has been modified to include the F05 and the new worksheet has a box to check if a member of the F05 unit is pregnant;
- If eligible, forward case to LDSS and send the new ACE form to DREP for processing indicating that the woman is pregnant; or

- If the **F05** AU is ineligible, leave any existing P-Track AUs open, transfer case electronically on CARES, and forward case record to LDSS for case completion.

3. **For a Pregnant Applicant with No Dependent Children:**
    - Pend the AU in P02 **(not F05)** and determine eligibility using the ACE process;
    - If eligible, forward case to LDSS and send the new ACE form to DREP for processing indicating that the woman is pregnant;
    - If P02 AU is ineligible due to excess income, it will trickle to P11; or
    - If the P11 AU is ineligible due to excess income, it will be denied by CARES.

If an applicant has no associated case(s) in a LDSS:

1. **For Family and Children Applicants:**
    - Pend the entire AU in **F05**. Be sure to code any active P13 or P14 child as an AC (financial responsibility field) on the STAT screen, and determine eligibility;
    - If the **F05** AU is ineligible due to excess income, leave existing P-Track AUs open. The **F05** AU will first trickle to F98 and then to F99. The F99 will sprout to any applicable P-Track coverage group. (See section regarding LHD Spend-down Eligibility Procedures on page 8 of this AT.); or
    - If eligible, close any existing P-Track AUs with the exception of P13 and P14 AUs. (Use CARES code 507.)
2. **For a Pregnant Applicant with Dependent Children:**
    - Pend the entire AU in **F05**. Be sure to code any active P13 or P14 child as an AC (financial responsibility field) on the STAT screen, and determine eligibility;
    - If the **F05** AU is ineligible due to excess income, leave existing P-Track AUs open. The **F05** AU will first trickle to F98 and then to F99. The F99 will sprout to any applicable P-Track coverage group. (See section regarding LHD Spend-down Eligibility Procedures on page 8 of this AT.); or
    - If eligible, close any existing P-Track AUs with the exception of P13 and P14 AUs. (Use CARES code 507.)
3. **For a Pregnant Applicant with No Dependent Children:**
    - Pend the AU as P02 **(not F05)** and determine eligibility;
    - If the P02 AU is ineligible due to excess income, it will trickle to P11; or
    - If the P11 AU is ineligible due to excess income, it will be denied by CARES.

RETROACTIVE ELIGIBILITY

1. **For applications received between 7/1/08 and 9/30/08:**
    - If the applicant requests retroactive eligibility, the case manager must determine eligibility for the retroactive months using **pre-Medicaid expansion rules for F05**; and
    - For the retroactive period, all assets and income must be counted and verified. In addition, medical bills must be submitted.
2. **For applications received after 10/01/08:**
    - For this period, assets will not be counted and income need not be verified for the **F05** group;
    - Retroactive eligibility shall be determined using the **new Medicaid rules and procedures**;
    - Unless the AU is currently in spend-down, there is no requirement to submit medical bills for retroactive months; and
    - The LHD will complete retroactive determinations of eligibility unless the case is eligible for ACE processing or is ineligible due to excess income. If the case is ineligible due to excess income, forward it to the LDSS (See section regarding Spend-down Eligibility Procedures on page 8 of this AT.)

REDETERMINATIONS

1. Use the same procedures for redeterminations as for initial applications. Please note the following **reminders:**
    - Verification of income will not be mandatory;
    - Do not consider assets for the **F05** coverage group;
    - The face-to-face interview will not be mandatory;
    - Any changes in health insurance must be verified; and
    - Child care expenses must be verified.
2. If a recipient in M (preserved) status for a F99 AU (after 7/1/08) contacts the LDSS for any reason, the LDSS must conduct an unscheduled MA redetermination because the spend-down household may become eligible for MA as a result of expansion. If the customer's income is below the income standard for the **F05** AU, the F99 AU should be closed (using the 559 code in the client RSN column) and the household must be determined eligible in the **F05** AU. Remember to change the certification period end date on the CARES MAFI screen to match the original F99 AU certification end date.

SPEND-DOWN ELIGIBILITY

LHD Procedures

The LHD case manager will:

- Finalize **F05** AUs that are ineligible due to excess income that will trickle to F99;
- P13 from MAFI screen and enter the following text, **"In addition to providing medical bills, you must provide proof of all assets before your eligibility for Medicaid can be determined"**;
- Send the "Pending Medical Assistance Determination Letter" (CARES letter 0118) requesting that the customer provide verification of assets and medical bills to the LDSS; and
- Transfer the case electronically on CARES and forward the case record to the LDSS.

LDSS Procedures

The LDSS case manager will:

- Finalize **F05** AUs that are ineligible due to excess income that will trickle to F99;
- P13 from MAFI screen and enter the following text, "**In addition to medical bills, you must provide proof of all assets before your eligibility for Medicaid can be determined**"; and
- Send the "Pending Medical Assistance Determination Letter" (CARES letter 0118) requesting that the customer provide verification of assets and medical bills.

If only verification of assets is subsequently provided:

- The LDSS case manager must enter asset information and narration in CARES. If an applicant's/recipient's assets are **within** eligibility limits, the case manager must file information in the case record; or
- The LDSS case manager must enter asset information and narration in CARES. If an applicant's/recipient's assets **exceed** eligibility limits, the case manager must file information in the case record and CARES should close the F99 AU and send the correct closing notice.

NOTE: The case manager **must** review the CARES notice the following day to ensure the proper notice was sent to the customer. If no notice or an incorrect notice was sent, the case manager must send a manual letter in CARES. The letter **must** include the correct COMAR (10.09.24.08) and the appeal rights. Manual letters may have to be generated until CARES modifications have been completed.

If only medical bills are subsequently provided:

- The LDSS case manager must file information in the case record and

narrate in CARES. Medical bill information must **not** be entered in CARES because asset verification has not been provided.

If both assets and medical bills are subsequently provided:

- The LDSS case manager must enter the asset, medical bill information, and narration in CARES. If an applicant's/recipient's assets are **within** eligibility limits, CARES will send the correct eligibility notice. When customer meets spend-down eligibility, the case manager must remember to leave all existing P-Track AUs open. **When completing spend-down authorization, (Option X on AMEN screen) the case manager must remember to go back into the case through Option R on the AMEN screen for each month and code each active P-Track AU child as AC (financial responsibility field) on the STAT screen.**
- The LDSS case manager must enter the asset, medical bill information, and narration in CARES. If an applicant's/recipient's assets **exceed** eligibility limits, the case manager must file information in the case record and CARES should close the F99 AU and send the correct closing notice.

NOTE: The case manager **must** review the CARES notice the following day to ensure the proper notice was sent to the customer. If no notice or an incorrect notice was sent, the case manager must send a manual letter in CARES. The letter **must** include the correct COMAR (10.09.24.08) and the appeal rights. Manual letters may have to be generated until CARES modifications have been completed.

If none of the requested verification is provided:

- The AU remains in a preserved status for the six month consideration period and CARES will close the AU at the end of the consideration period.

Reminder

Eligibility must be determined within 30 days for pending cases transferred from the LHD to the LDSS. For an associated case, process the Medicaid application without waiting for needed verification.

PRIMARY ADULT CARE (PAC)

For Current PAC Recipients:

1. A match of children's Medicaid/MCHP cases will be performed with PAC cases in MMIS. Lists of these cases will be sent monthly to the LHD/LDSS where the active or pending cases are located;
2. PAC cases with a match to Medicaid/MCHP cases to will initially transition in MMIS only for 12 months with an end date of 6/30/09;
3. If no **F05** AU has been established in CARES by 4/30/09, a manual notice will be sent by DREP notifying the recipient that the case will close 6/30/09;
4. A match of children's Medicaid/MCHP cases will be performed with PAC cases in

MMIS. Lists of these cases will be sent monthly to the LHD/LDSS where the active or pending cases are located;

5. At the first Medicaid/MCHP redetermination **due after 7/1/08**, the LDSS case manager will:
    - Pend the entire assistance unit in **F05**. Be sure to code any active P13 or P14 child as an AC (financial responsibility field) on the STAT screen, and determine eligibility;
    - If eligible, close any existing P-Track AUs with the exception of P13 and P14 AUs. (Use CARES code 507.); or
    - If the **F05** AU is ineligible due to excess income, leave existing P-Track AUs open. The **F05** AU will trickle to F98 and F99. (See section regarding Spend-down Eligibility Procedures on page 8 of this AT.)
6. At the first Medicaid/MCHP redetermination **due after 7/1/08**, the LHD case manager will:
    - Pend the entire AU in **F05**. Be sure to code any active P13 or P14 child as an AC (financial responsibility field) on the STAT screen, and determine eligibility;
    - If eligible, close any existing P-Track AUs with the exception of P13 and P14 AUs. (Use CARES code 507.); or
    - If the **F05** AU is ineligible due to excess income, leave any existing P-Track case open. Finalize **F05** AU which will trickle to F98, and then F99. Send request for assets letter, transfer the case electronically on CARES and forward the case record to the LDSS.
7. PAC case managers will follow up to ensure cases are on CARES.

For New PAC Applications Filed 7/1/08 or After:

1. If there is an associated AU, PAC case managers will pend and forward case to the appropriate LDSS or LHD for processing; and
2. If there is no associated AU, PAC case managers will pend and forward to LHD for processing.

PLEASE REMEMBER TO NARRATE ALL INFORMATION IN CARES.

For your convenience, the following documents are included as a reference:

- **Quick Reference Guide to Medical Care Program Coverage Groups and HealthChoice Eligibility,**
- **Medicaid Income and Assets Consideration Guide, and**
- **Monthly Income and Asset Guidelines Chart.**

INQUIRIES:

For policy questions, contact the DHMH Division of Eligibility Policy and MCHP at 410-767-1463 or 1-800-492-5231 (select option 2 and request extension 1463). For CARES questions, contact Debbie Simon at 410-238-1363.

cc: DHR Executive Staff
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