Table of Contents Section 2 to Attch 2.2

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State: Maryland

SECTION 2 - COVERAGE AND ELIGIBILITY

Citation
42 CFR
435.10 and
Subpart J

2.1 Application, Determination of Eligibility and Furnishing Medicaid

(a) The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

Revision: HCFA-PM-93-2 (MB)
MARCH 1993

State: Maryland

Citation		
42 CFR 435.914 1902(a)(34) of the Act	2.1 (b) (1)	Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in ATTACHMENT 2.6-A.
1902(e)(8) and 1905(a) of the Act	(2)	For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month in which the individual is first determined to be a qualified Medicare beneficiary. ATTACHMENT 2.6-A specifies the requirements for determination of eligibility for this group.
1902(a)(47) and 1920 of the Act	X (3)	Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. ATTACHMENT 2.6-A specifies the requirements for determination of eligibility for this group.

42 CFR 434.20

(c) The Medicaid agency elects to enter into a risk contract with an HMO that is--

X Qualified under title XIII of the Public Health Service Act or is provisionally qualified as an HMO pursuant to section 1903(m)(3) of the Social Security Act.

X Not Federally qualified, but meets the requirements of 42 CFR 434.20(c) and is defined in ATTACHMENT 2.1-A.

___ Not applicable.

APR 28 1993

TN No. 93-22
Supersedes TN No. 92-11

Approval Date _____ Effective Date JAN 01 1993

Revision: HCFA-PM-91-8 (MB) October 1991 OMB No.

State/Territory: Maryland

Citation		
1902(a)(55) of the Act	2.1(d)	The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described in §1902(a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), and (a)(10)(A)(ii)(IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the ADFC form except as permitted by HCFA instructions.

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.1 Application, Determination of Eligibility and Furnishing Medicaid (Continued)

1902(e)(13) of the Act

☒ (e) Express Lane Option. The Medicaid State agency elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of Medicaid eligibility. The Medicaid State agency agrees to meet all of the Federal statutory and regulatory requirements for this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after September 30, 2013.

(1) The Express Lane option is applied to:
☐ Initial determinations ☒ Redeterminations
☐ Both

(2) A child is defined as younger than age:
☐ 19 ☐ 20 ☒ 21

(3) The following public agencies are approved by the Medicaid State agency as Express Lane agencies:

The Express Lane Agency at redetermination will be the Maryland Department of Human Services (DHS). DHS is the administrator of the Supplemental Nutrition Assistance Program (SNAP) in the state of Maryland.

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.1 **Application, Determination of Eligibility and Furnishing Medicaid** (Continued)

(4) The following component/components of Medicaid eligibility are determined under the Express Lane option. Also, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between Medicaid eligibility determinations for such children and the determination under the Express Lane option.

At redetermination, the Maryland Medical Assistance Program will renew Medicaid eligibility for children under age 21 who are receiving SNAP benefits, despite differences in household composition and income-counting rules. The State will renew Medicaid eligibility for SNAP participants under age 21 whose gross income as determined by SNAP is under the applicable modified adjusted gross income (MAGI)-based income standard for Medicaid eligibility without conducting a separate MAGI-based income determination. The highest MAGI threshold is 200% FPL. The highest non-MAGI income standard is 300% FBR. This process will apply to the MAGI and non-MAGI population.

The Maryland Medical Assistance Program will identify children for both Medicaid and SNAP through a data match. This process will be used for renewals only. All members eligible for this process have completed an initial application and have been approved for both Medicaid and SNAP eligibility.

The following summarizes SNAP methodologies in determining eligibility based on income:

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.1 **Application, Determination of Eligibility and Furnishing Medicaid** (Continued)

SNAP Budget Unit: May be one person or a group of individuals living together who purchase food and prepare meals together.

SNAP Gross Income Limit: 200% FPL for categorically eligible households and 130% for non-categorically eligible households. Medicaid will use SNAP income data for all children's groups whose income standards are at or below 200% FPL for the MAGI population and 300% FBR for the non-MAGI population.

SNAP Income Deductions:

- Income deductions are used to determine benefit level and eligibility for all SNAP households included in this process except for those with an elderly or disabled member who are required to meet the net income standard.
- For households with an elderly or disabled member, a 100% net income threshold must be met by using the following disregards:
  - Standard deduction determined according to household size in accordance with 7 CFR 273.9(d)(1).
  - Excess medical deduction for non-reimbursable medical expenses in excess of $35 a month.

SNAP Income Exclusions:

SNAP Income Exclusions are items that are deducted from the household's gross income to determine eligibility and benefit level after gross income has been calculated. The following are deducted from a household’s gross income:

- Standard deduction as described above;
- Earned income deduction equal to 20% of gross monthly earned income and 50% for self-employment income;
- Excess medical deduction;
- Dependent care deduction for children under 18 and people with disabilities of any age;
- Child support deduction for legally obligated child support payments to a non-household member;
- Excess shelter deduction;
- Standard utility allowances;
- Infrequent and irregular incomes not in excess of $30 per recipient per quarter;

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.1 **Application, Determination of Eligibility and Furnishing Medicaid** (Continued)

- Educational assistance, including but not limited to: grants, scholarships, fellowships, education loans on which payment is deferred, work-study, veterans' educational benefits;
- Other loans including loans from private individuals and commercial institutions;

Excluded Income:

Excluded Income is non-countable income. The following are excluded from income counting for all households and are not included when calculated gross income:

- Monies received and used for the care and maintenance of a third-party beneficiary who is not a household member;
- Earned income of elementary or high school students who are members of the household and are 17 years old or younger;
- Non-recurring lump-sum payments;
- Reimbursements for past or future expenses that do not exceed actual incurred expenses and do not represent a gain or benefit to the household;
- Income in-kind;
- Vendor payments (money or an in-kind payment not owed to the household and paid directly to someone outside the household for a household expense);
- Child support payments received by TCA recipients;
- Income excluded by federal statute;
- Cash donations or contributions based on need from private organizations;
- Earned income tax credit payments;
- Income withheld from an assistance payment, earned income, or other source that is voluntarily or involuntarily returned to the source to repay a prior overpayment received from that income source;
- Reverse mortgages;
- Housing and Urban Development (HUD) utility reimbursements or allowances;
- Interest earned on bank accounts;
- Cost of producing self-employment income;
- Guaranteed Basic Income (GBI).

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation(s)

2.1 **Application, Determination of Eligibility and Furnishing Medicaid** (Continued)

(5) Check off and describe the option used to satisfy the Screen and Enroll requirement before a child may be enrolled under title XXI.

☐ (a) Screening threshold established by the Medicaid agency as:

☐ (i) ____ percentage of the Federal poverty level which exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points: specify _____; or

☐ (ii) ____ percentage of the FPL (describe how this reflects the value of any differences between income methodologies of Medicaid and the Express Lane agency: _____ _____); or

☐ (b) Temporary enrollment pending screen and enroll.

☒ (c) State's regular screen and enroll process for CHIP.

☐ (6) Check off if the State elects the option for automatic enrollment without a Medicaid application, based on data obtained from other sources and with the child's or family's affirmative consent to the child's Medicaid enrollment.

☐ (7) Check off if the State elects the option to rely on a finding from an Express Lane agency that includes gross income or adjusted gross income shown by State income tax records or returns.

State: MARYLAND

Citation
42 CFR
435.10

2.2 Coverage and Conditions of Eligibility

Medicaid is available to the groups specified in ATTACHMENT 2.2-A.

☐ Mandatory categorically needy and other required special groups only.

☐ Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.

☐ Mandatory categorically needy, other required special groups, and specified optional groups.

☒ Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.

All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(i)(IV), (V), and (VI), 1902(a)(10)(A)(ii)(XI), 1902(a)(10)(E), 1902(l) and (m), 1905(p), (q) and (s), 1920, and 1925 of Act are met.

Revision: HCFA-PM-87-4 (BERC) MARCH 1987 **OMB No.:** 0938-0193

State: Maryland

Citation
435.10 and 435.403, and 1902(b) of the Act, P.L. 99-272 (Section 9529) and P.L. 99-509 (Section 9405)

2.3 **Residence**

Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address.

Revision: HCFA-PM-87-4 (BERC) MARCH 1987 **OMB No.:** 0938-0193

State: Maryland

Citation	2.4 Blindness
42 CFR 435.530(b) 42 CFR 435.531 AT-78-90 AT-79-29	All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A.

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No. 0938-

State: _____

Citation	2.5 Disability
42 CFR 435.121, 435.540(b) 435.541	All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in Item A.13.b. of ATTACHMENT 2.2-A of this plan.

Revision: HCFA-PM-92-1 (MB)
FEBRUARY 1992

State: Maryland

Citation(s)

42 CFR
435.10 and
Subparts G & H
1902(a)(10)(A)(i)
(III), (IV), (V),
(VI), and (VII),
1902(a)(10)(A)(ii)
(IX), 1902(a)(10)
(A)(ii)(X), 1902
(a)(10)(C),
1902(f), 1902(l)
and (m),
1905(p) and (s),
1902(r)(2),
and 1920

2.6 Financial Eligibility

(a) The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A.

Revision: HCFA-PM-86-20 (BERC) OMB-No. 0938-0193
SEPTEMBER 1986

State/Territory: Maryland

Citation	2.7	Medicaid Furnished Out of State
431.52 and 1902(b) of the Act, P.L. 99-272 (Section 9529)		Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.

ATTACHMENT 2.1-A

A Health Maintenance Organization (HMO) is defined as an entity which has a Certificate of Authority to operate as a health maintenance organization issued by the Insurance Commission, Maryland Department of Licensing and Regulation.

Maryland HMOs satisfy all the requirements of 42 CFR 434.20(c) through strict compliance with existing Code of Maryland Regulations (COMAR). Specific references are as follows:

-Organization's Primary Purpose-

"Health Maintenance Organization-Medical Assistance (HMO-MA)" means an organization which has demonstrated professional and financial ability to deliver specific health care services (as defined in Health-General Article, §19-701, Annotated Code of Maryland) to an enrolled group of persons consistent with applicable Federal and State laws and has contracted with this Department to deliver services to enrolled Medical Assistance Program recipients (COMAR 10.09.16.02F).

"HMO-MA benefit package" means all health services to which recipients are entitled under the Medical Assistance Program exclusive of services in a skilled nursing facility, intermediate care facility, chronic hospital, mental hospital, and other services specifically excluded in the contract (COMAR 10.09.16.02G),

-Accessibility to Services-

"HMO-MA benefit package" means all health services to which recipients are entitled under the Medical Assistance Program exclusive of services in a skilled nursing facility, intermediate care facility, chronic hospital, mental hospital, and other services specifically excluded in the contract (COMAR 10.09.16.02G).

"Marketing area" means a defined geographic area selected by the HMO-MA and approved by the Department in which the complete benefit package is available to all HMO-MA enrollees, and beyond which the HMO-MA is restricted from directly marketing its services (COMAR 10.09.16.02I).

-Risk of Insolvency -

The HMO-MA shall ensure that enrollees are not held liable for the debts of the HMO-MA in the event of the insolvency of the HMO-MA by:

(a)
Entering into subcontracts as required by §F of this regulation; and

(b)
Maintaining reserve funds, the amount of which may not be less than the sum of:

(i)
One months capitation revenue from the Department, and

(ii)
Three months; average expenditures by the HMO-MA for services rendered to enrollees by providers with whom the HMO-MA does not have subcontracts, including providers of emergency services [COMAR 10.09.16.04(C)(1)].

Attachment 2.1 - B

A Managed Care Organization (MCO) is defined by state law as 1) a state certified health maintenance organization that is authorized to receive medical assistance prepaid capitation payments or 2) a corporation that a) is a managed care system authorized to receive medical assistance prepaid capitation payments, b) enrolls only Medicaid program recipients, and c) operates within certain financial rules as discussed below.

MCOs are responsible for delivering specific health services under Maryland Medicaid's HealthChoice Program which operates under a federally approved 1115 waiver.

- Organization's Primary Purpose -

A Managed Care Organization under Maryland Medicaid's HealthChoice Program is an organization which has undergone an application review and demonstrated the professional and financial ability to provide specific health services (as defined in Health-General Article, Title 15, Subtitle 103, Annotated Code of Maryland) to an enrolled group of persons consistent with the applicable Federal and State laws and has contracted with this Department to deliver services to enrolled Medical Assistance Program recipients (COMAR 10.09.62 through 10.09.73)

The specific health care services for which MCOs are responsible consist of all services available to MA recipients as of January 1, 1996 with the exception of skilled nursing facility, intermediate care facility, chronic hospital, mental hospital, and other services specifically excluded by regulations COMAR 10.09.65

- Accessibility to Services -

"Local Access Area" means the local geographic area, as identified by the zip code groupings in COMAR 10.09.66.06E, that is located within the relevant MCO's service area and in which the relevant enrollee resides.

"Service Area" means a geographical area comprised of one or more of Maryland's counties, with each selected county included in its entirety.

- Risk of Insolvency -

Each managed care organization shall be actuarially sound. Except as otherwise provided in this section, the surplus that a managed care organization is required to have shall be paid in full. A managed care organization shall have an initial surplus that exceeds the liabilities of the managed care organization by at least $1,500,000. In consultation with the secretary (of the Department), the insurance commissioner may adjust the initial surplus requirement for a managed care organization that is not licensed as a health maintenance organization.

An managed care organization shall have initial surplus that exceeds liabilities by at least $1,250,000. if a managed care organization has initial surplus that is at least $1,250,000 but less than $1,500,000, prior to approval, the department shall designate funds under paragraph (1)(ii) of this subsection sufficient to provide an initial surplus of at least $1,500,000

Each managed care organizations shall maintain a surplus that exceeds the liabilities of the managed care organization in the amount that is at least equal to the greater of $750,000 or 5 percent of the subscription charges earned during the prior calendar year as recorded in the annual report filed by the managed care organization with the commissioner.

No managed care organization shall be required to maintain a surplus in excess of a value of $3,000,000. For the protection of the managed care organization's enrollees and creditors, the applicant shall deposit and maintain in trust with the state treasurer $100,000 in cash or government securities.

State: Maryland

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
		2. Deemed Recipients of AFDC.
	1902(a)(10)(A)(i)(I) of the Act	b. Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e)(6) of the Act.
	402(a)(22)(A) of the Act	c. Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.
	406(h) and 1902(a)(10)(A)(i)(I) of the Act	d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.
	1902(a) of the Act	e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

MD 13-00200-MM1 superceded A.2.b and A.2.c

*Agency that determines eligibility for coverage.

State: Maryland

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

407(b), 1902 (a)(10)(A)(i) and 1905(m)(1) of the Act

3. Qualified Family Members

~~Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under section 407 of the Act because the principal wage earner is unemployed.~~

~~Qualified family members are not included because cash assistance payments may be made to families with unemployed parents for 12 months per calendar year.~~

MD 13-0020-MM1
superceded section 2.A.3

1902(a)(52) and 1925 of the Act

4. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)

*Agency that determines eligibility for coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Maryland

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1902(a)(10)(A)(i)(V) and 1905(m) of the Act MD-13-0020-MM1 superceded A.10	~~10. Individuals other than qualified pregnant women and children under item A.7. above who are members of a family that would be receiving AFDC under section 407 of the Act if the State had not exercised the option under section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC~~
1902(e)(5) of the Act	11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.
1902(e)(6) of the Act	b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Maryland

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

1902(e)(4) of the Act

12. Deemed Newborns: **(42 CFR 435.117, 1902(e)(4) of the Act)**

A child born in the United States to a woman who was eligible for and receiving Medicaid (including coverage of an alien for labor and delivery as emergency medical services) for the date of the child's birth, including retroactively. The child is deemed eligible for one year from birth.

42 CFR 435.120

13. Aged, Blind, and Disabled Individuals Receiving Cash Assistance

X a. Individuals receiving SSI:

This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act.

X Aged
X Blind
X Disabled

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

435.121

1619(b)(1) of the Act

13. /7 b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.)

___ Aged
___ Blind
___ Disabled

The more restrictive categorical eligibility criteria are described below:

(Financial criteria are described in ATTACHMENT 2.6-A).

*Agency that determines eligibility for coverage.

NOV 05 1992

NOV 0 1 1991

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1902(a)(10)(A)(i)(II) and 1905(q) of the Act

14. Qualified severely impaired blind and disabled individuals under age 65, who--

a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or

b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must--

(1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;

(2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;

(3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

*Agency that determines eligibility for coverage.

Agency* Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and

(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

/_/ Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
	A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1619(b)(3) of the Act	/7 The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1634(c) of the Act	15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who--
		a. Are at least 18 years of age;
		b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.
		/_/ c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.
		/_/ d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.
	42 CFR 435.122	16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under $435.230), because of requirements that do not apply under title XIX of the Act.
	42 CFR 435.130	17. Individuals receiving mandatory State supplements.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.131

18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.

/X/ In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

X Aged X Blind X Disabled

/ / Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.132 19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they--

a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and

b. Remain institutionalized; and

c. Continue to need institutional care.

42 CFR 435.133 20. Blind and disabled individuals who--

a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and

b. Were eligible for Medicaid in December 1973 as blind or disabled; and

c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.134 21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

☐ Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

☐ Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

☐ Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

*Agency that determines eligibility for coverage.

Agency* Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.135 22. Individuals who --

a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and

b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

☐ Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.

☐ Not applicable because the State applies more restrictive eligibility requirements than those under SSI.

☐ The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1634 of the Act

23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.

☐ Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.

☐ The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equalling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

*Agency that determines eligibility for coverage.

State/Territory: MARYLAND

Agency*	Citation(s)	Groups Covered
	1634(d) of the Act	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

24. Disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A.

____ The State applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.

____ In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in § 1634(d)(1)(A) in determining the income of the individual, but does not disregard any more of this income than would reduce the individual's income to the SSI income standard.

____ In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in §1634(d)(1)(A) in determining the income of the individual, which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to disregarded is specified in Supplement 4 to Attachment 2.6-A.

____ In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in § 1634(d)(1)(A) in determining the income of the individual

*Agency that determines eligibility for coverage.

State: Maryland

Agency	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
	1902(a)(10)(E)(i), 1905(p) and 1860D-14(a)(3)(D) of the Act	25. Qualified Medicare Beneficiaries – a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act); b. Whose income does not exceed 100 percent of the Federal poverty level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index. (Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)
	1902(a)(10)(E)(ii), 1905(p)(3)(A)(i), 1905(p) and 1860D-14(a)(3)(D) of the Act	26. Qualified Disabled and Working Individuals – a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act; b. Whose income does not exceed 200 percent of the Federal poverty level;

State: Maryland

Agency	Citation(s)	Groups Covered

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

c. Whose resources do not exceed two times the SSI resource Limit; and

d. Who are not otherwise eligible for medical assistance under Title XIX of the Act.

(Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)

1902(a)(10)(E)(iii), 1905(p)(3)(A)(ii), and 1860D-14(a)(3)(D) of the Act

27. Specified Low-Income Medicare Beneficiaries --

a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act);

b. whose income is greater than 100 percent but less than 120 percent of the Federal poverty level; and

c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.

(Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)

State: Maryland

Agency	Citation(s)	Groups Covered
		A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)
	1634(e)	28. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) of (v) of Section 1611(e)(3)(A) shall be treated, for purposes of Title XIX, as receiving SSI benefits for the month.
	1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii) and 1860D-14(a)(3)(D) of the Act	29. Qualifying Individuals -- a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act); b. whose income is at least 120 percent but less than 135 percent of the Federal poverty level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index. (Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)

State: Maryland

Agency*

Citation	Groups Covered

B. Optional Groups Other Than the Medically Needy

42 CFR 435.210 1902(a)(10)(A)(ii) and 1905(a) of the Act

X 1. Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional State supplement as specified in 42CFR 435.230, but who do not receive cash assistance.

X The plan covers all individuals as described above.

__ The plan covers only the following group or groups of individuals:

__ Aged
__ Blind
__ Disabled
__ ~~Caretaker relatives~~
__ ~~Pregnant Women~~

MD 13-0020-MM1 superceded language related to Caretaker relatives and Pregnant omen

42 CFR 435.211

X 2. Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

*Agency that determines eligibility for coverage.

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.212 & 1902(e)(2) of the Act

/ / 3. The State deems as eligible those individuals who become otherwise ineligible for Medicaid while enrolled in an HMO qualified under title XIII of the Public Health Service Act or while enrolled in an entity described in sections 1903(m)(2)(B)(iii), (E), or (G) or 1903(m)(6) of the Act, but who have been enrolled in the HMO or entity for less than the minimum enrollment period listed below. The HMO or entity must have a risk contract as specified in 42 CFR 434.20(a). Coverage under this section is limited to HMO services and family planning services described in section 1905(a)(4)(C) of the Act.

The minimum enrollment period is _____ (not to exceed six months).

The State measures the minimum enrollment period from:

/ / The date beginning the period of enrollment in the HMO or other entity, without any intervening disenrollment, regardless of Medicaid eligibility.

/ / The date beginning the period of enrollment in the HMO as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

*Agency that determines eligibility for coverage.

State of Maryland

Agency* citation(s)		Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
42 CFR 435.217	X	4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and Community –based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The groups of groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group (a) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.

NOTE: PACE enrollees eligible at the Special income level equal to 300% of the SSI Federal Benefit Rate will be covered under institutional rules.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(10)(A)(ii)(VII) of the Act

☑ 5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

☑ The State covers all individuals as described above.

☑ The State covers only the following group or groups of individuals:

___ Aged
___ Blind
___ Disabled
___ Individuals under the age of--
  ___ 21
  ___ 20
  ___ 19
  ___ 18
___ Caretaker relatives
___ Pregnant women

*Agency that determines eligibility for coverage.

State: Maryland

Agency*	Citation (s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.232 [X] 10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act.

The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is - -

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in the State.

d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.

X (1) All aged individuals.

X (2) All blind individuals.

X (3) All disabled individuals.

State: Maryland

Agency*	Citation (s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.232

X (4) Aged individuals in domiciliary facilities or other facilities or other group living arrangements as defined under SSI.

X (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

X (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (7) Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230

___ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

___ (9) Individuals in additional classifications approved by the Secretary as follows:

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.230
435.121
1902(a)(10)(A)(ii)(XI) of the Act

/ 11. Section 1902(f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act.

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in each classification and available on a Statewide basis.

d. Paid to one or more of the classifications of individuals listed below:

___ (1) All aged individuals.

___ (2) All blind individuals.

___ (3) All disabled individuals.

State: MARYLAND

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

_____ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

_____ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

_____ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

_____ (7) Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

_____ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

_____ (9) Individuals in additional classifications approved by the Secretary as follows:

State: MARYLAND

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of - living differences.

_____ Yes

_____ No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

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August 1991

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State: Maryland

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.236 / 1902 (a)(10)(A)(ii)(V) of the Act

☒ 12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A.

☒ The State covers all individuals as described above.

☐ The State covers only the following group or groups of individuals:

1902 (a)(10)(A)(ii) and 1905(a) of the Act

___ Aged
___ Blind
___ Disabled
___ Individuals under the age of--
  ___ 21
  ___ 20
  ___ 19
  ___ 18
___ Caretaker relatives
___ Pregnant women

Agency* Citation (s)	Groups Covered
	B. Optional Groups Other Than the Medically Needy (Continued)
1902 (e) (3) of the Act	⑤ 13. Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in a medical institution, and for whom the State has made a determination as required under section 1902 (e) (3) (8) of the Act. Supplement 3 to ATTACHMENT 2.2-A describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.
1902 (a) (10) (A) (ii) (IX) and 1902 (1) of the Act	~~14. The following individuals who are not mandatory categorically needy whose income does not exceed the income level specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A:~~ ~~a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy) with income above the mandatory level and less than or equal to 250 percent of the Federal poverty income level, and~~ ~~b. Infants under one year old with Income above the mandatory level and not more than 185 percent of the Federal poverty income level.~~

MD 13-0020-MM1 superceded section B.14

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(ii)(X) and 1902(m)(1) and (3) of the Act — 17

16. Individuals--

a. Who are 65 years of age or older or are disabled, as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group.

b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and

c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in ATTACHMENT 2.6-A.

State/Territory: Maryland

Citation	Groups Covered
	B. Optional Groups Other Than the Medically Needy (Continued)
1906 of the Act	18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of 0 months.
1902(a)(10)(F) and 1902(u)(1) of the Act	19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid extenditures for an equivalent set of services. See Supplement 11 to Attachment 2.6-A.

Attachment 2.2A, page 23c, partially superceded by TN: 13-0020-MM1,
Superceded section: B.22, Approved 12/18/2013, Effective 1/1/2014, Archived 5/17/19

___ The following reasonable classifications of children described above who are under age____ (18, 19) with family income at or below the _____ percent of the Federal poverty level specified for the classifications:

(ADD NARRATIVE DESCRIPTION(S) OF THE REASONABLE CLASSIFICATION(S) AND THE PERCENT OF THE FEDERAL POVERTY LEVEL USED TO ESTABLISH ELIGIBILITY FOR EACH CLASSIFICATION.)

1902(e) (12) of the Act

__21. A child under age ____ (not to exceed age 19) who has been determined eligible is deemed to be eligible for a total of ____ months (not to exceed 12 months) regardless of changes in circumstances other than attainment of the maximum age stated above.

1920A of the Act

__22. ~~Children under age 19 who are determined by a "qualified entity" (as defined in §1920A(b)(3)(A)) based on preliminary information, to meet the highest applicable income criteria specified in this plan.~~

~~The presumptive period begins on the day that the determination is made. If an application for Medicaid is filed on the child's behalf by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on the day that the State agency makes a determination of the eligibility based on that application. If an application is not filed on the child's behalf by the last day of the month following the month the determination of presumptive eligibility was made, the presumptive period ends on that last day.~~

MD-13-0020-MM1 superceded section B.22

TN No. 99-1 Approval Date DEC 23 1998 Effective Date 7/1/98

Supersedes

TN No. _____

State: Maryland

Agency * Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(10)(A)(ii)(XVIII) of the Act

____ 23. Women who:

a. have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix;

b. are not otherwise covered under creditable coverage, as defined in section 2701 (c) of the Public Health Service Act;

c. are not eligible for Medicaid under any mandatory categorically needy eligibility group; and

d. have not attained age 65.

___ 24. Women who are determined by a "qualified entity" (as defined in 1920B (b) based on preliminary information, to be a woman described in 1902 (aa) the Act related to certain breast and cervical cancer patients. The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.

The State covered this group between April 2002 and December 31st, 2013.

State/Territory: Maryland

Citation			Groups Covered
B.	Optional Groups Other Than the Medically Needy (Continued)		
1902(a)(10)(A) (ii)(XIII) of the Act	[ ]	23.	BBA Work Incentives Eligibility Group - Individuals with a disability whose net family income is below 250 percent of the Federal poverty level for a family of the size involved and who, except for earned income, meet all criteria for receiving benefits under the SSI program. See page 12c of Attachment 2.6-A.
1902(a)(10)(A) (ii)(XV) of the Act	[X]	24.	TWWIIA Basic Coverage Group - Individuals with a disability at least 16 but less than 65 years of age whose income and resources do not exceed a standard established by the State. See page 12d of Attachment 2.6-A.
1902(a)(10)(A) (ii)(XVI) of the Act	[]	25.	TWWIIA Medical Improvement Group - Employed individuals at leas 16 but less than 65 years of age with a medically improved disability whose income and resources do not exceed a standard established by the State. See page 12h of Attachment 2.6A. NOTE: If the State elects cover this group, it MUST also cover the eligibility group described in No. 24 above.

State: MARYLAND

Groups Covered

C. Optional Coverage of the Medically Needy

42 CFR 435.301 — This plan includes the medically needy.

☐ No.

☒ Yes. This plan covers:

1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.

1902(e) of the Act — 2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.

1902(a)(10)(C)(ii)(I) of the Act — 3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.

State: Maryland

Groups Covered

MD-13-0020-MM1 superceded C.4

C. Optional Coverage of Medically Needy (continued)

~~4. Reserved for future use~~

42 CFR 435.308

5. X a. Financially eligible individuals who are not described in section C.3 above and who are under the age of -

X 21
__ 20
__ 19
__ 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training

☐ b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below:

___ (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

___ (a) In foster homes (and who are under the age of ___),

___ (b) In private institutions (and are under the age of ___).

Agency* Citation(s) Groups Covered

C. Optional Coverage of Medically Needy (Continued)

___ (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ___ ___).

___ (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of _____).

___ (3) Individuals in NFs (who are under the age of _____). NF services are provided under this plan.

___ (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of _____).

___ (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of ___). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

___ (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

Agency*	Citation(s)	Groups Covered

C. Optional Coverage of Medically Needy (Continued)

42 CFR 435.310	/X/	6. Caretaker relatives.
42 CFR 435.320 and 435.330	/X/	7. Aged individuals.
42 CFR 435.322 and 435.330	/X/	8. Blind individuals.
42 CFR 435.324 and 435.330	/X/	9. Disabled individuals.
42 CFR 435.326	/ /	10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.
435.340		11. Blind and disabled individuals who: a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; b. Were eligible as medically needy in December 1973 as blind or disabled; and c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.

Citation(s)	Groups Covered
	C. Optional Coverage of Medically Needy (Continued)
1906 of the Act	12. Individuals required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of 0 months.

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

☐ No. Does not apply. State does not cover optional categorically needy groups.

☒ Yes. State covers the following optional categorically needy groups.
(Select all that apply):

(a) ☒ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used:
(Select one):

☒ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

For groups in the state plan home and community-based services group under 42 CFR 42 CFR § 435.219 only, after SSI countable income, the State disregards income in the amount of the difference between 150% of the Federal Poverty Level and 300% of the Federal Poverty Level.

☐ OTHER (*describe*):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.
Income limit: (*Select one):*

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify):* _____%

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s)):*

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 114 hours per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, and Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

MAGI-Based Income Methodologies **S10**

1902(e)(14)
42 CFR 435.603

☑ The state will apply Modified Adjusted Gross Income (MAGI)-based methodologies as described below, and consistent with 42 CFR 435.603.

In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014, or the next regularly-scheduled renewal of eligibility, whichever is later, if application of such methods results in a determination of ineligibility prior to such date.

In determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

○ The pregnant woman is counted just as herself.

○ The pregnant woman is counted as herself, plus one.

◉ The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

◉ Current monthly household income and family size

○ Projected annual household income and family size for the remaining months of the current calendar year

In determining current monthly or projected annual household income, the state will use reasonable methods to:

☒ Include a prorated portion of a reasonably predictable increase in future income and/or family size.

☒ Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

In determining eligibility for Medicaid, an amount equivalent to 5 percentage points of the FPL for the applicable family size will be deducted from household income in accordance with 42 CFR 435.603(d).

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.

○ Yes ◉ No

Medicaid Eligibility

☑ The age used for children with respect to 42 CFR 435.603(f)(3)(iv) is:

○ Age 19

◉ Age 19, or in the case of full-time students, age 21

PRA Disclosure Statement

Modified Adjusted Gross Income (MAGI) Conversion Plan

This MAGI Conversion Plan is being submitted to CMS by **Maryland** as required by Section 1902(e)(14)(E) of the Social Security Act, which requires each state to submit for approval the income eligibility thresholds for Medicaid and the Children's Health Insurance Program (CHIP) proposed to be established using modified adjusted gross income (MAGI). As described in the December 28, 2012 State Health Officials' Letter on Modified Adjusted Gross Income (MAGI) income conversion, states can choose among three options to convert net standards for Medicaid and CHIP to MAGI equivalent standards. [1] The purpose of the MAGI Conversion Plan is to provide CMS with information about each state's MAGI conversion methodology, as well as the data used and results of conversion. CMS will be reviewing the submitted materials and notifying the State with their approval or disapproval by **June 15, 2013**.

Eligibility and FMAP claiming conversions. States are required to submit information about their conversion methodology, data and results for income conversions related to eligibility and those required for FMAP claiming in accordance with CMS' FMAP rule. For additional information about the FMAP rule, please see: https://s3.amazonaws.com/public-inspection.federalregister.gov/2013-07599.pdf.

Note about Income Eligibility Conversions and State Plan Amendments: Converted income standards will be used to set maximum MAGI-equivalent standards for adults in 2014 and will be used as the actual income standard in effect for children through October 2019. States will use the state plan amendment (SPA) process to identify the minimum and maximum MAGI-equivalent standards and to select the state's MAGI-based income standard for each eligibility group to which MAGI will apply in 2014. For adults for whom the Maintenance of Effort requirement expires in 2014, the selected income standard in the SPA will be anywhere between the minimum allowed and the maximum derived through the income conversion process.

Please indicate the MAGI conversion method chosen by your state and follow the appropriate directions:

☐ **Option 1** – Standardized Methodology with SIPP data
Attach Excel spreadsheet with finalized SIPP results of eligibility and FMAP conversions to this cover page and submit to incomeconversion@cms.hhs.gov.

✓ **Option 2** – Standardized Methodology with State data
Please follow the instructions below and submit this plan to incomeconversion@cms.hhs.gov.

☐ **Option 3** – State proposed Alternative Method
Please follow the instructions below and submit this plan to incomeconversion@cms.hhs.gov.

[1] SHO letter available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO12003.pdf

	Part 1 – Conversions for Eligibility		Part 2 – Conversions for FMAP Claiming	
	Pages to Complete	Due Date	Pages to Complete	Due Date
Standardized Methodology	Page 1	May 31, 2013	Page 1	August 1, 2013
Standardized Methodology with State Data	Page 3-10	April 30, 2013	Pages 13-18	August 1, 2013
Alternative Methodology	Page 3-12	April 30, 2013	Pages 13-18	August 1, 2013

Standardized Methodology with State Data Method
and
Alternative Method:

Please provide a state contact who can answer questions about the conversion plan, data, and methods:

Name: Alice Middleton Title: Deputy Director, Planning Administration, Health Care Financing, DHMH

E-mail: alice.middleton@maryland.gov Phone: 410-767-3419

Supplemental Information: In addition to the information provided in the attached MAGI Conversion Plan, during the review and approval process, CMS may determine that supplemental information regarding the income conversion results is necessary. If CMS determines that a supplemental review of these results is necessary, your state may be required to submit:

- Descriptive statistics of the data used. Such descriptive statistics could include for each eligibility group converted with state data:
  - Net income statistics and disregard statistics for the full population or sample and for the population used in conversion (e.g., the 25% band) including: Total N, Mean Net Income, Standard Deviation of Mean Net Income, Median Net Income, and Number of individuals with Positive Net Income
- Data files used for conversion
- Annotated programming code used in the analysis

PART 1: ELIGIBILITY CONVERSIONS- TABLE 1 – DUE APRIL 30, 2013

For States Using
Standardized Methodology with State Data
Or
Alternative Method

Please fill out Table 1 below to provide CMS with information about how state data were used for MAGI income conversion. All cells in rows for eligibility groups that do not have a converted income standard in your state (for example, if your state does not cover independent foster care adolescents or does not apply an income standard to this group) should be marked "N/A."

Instructions for Table 1:

SIPP results used: Your state may have used SIPP results for converting some groups. For conversions based on SIPP, please mark yes in the first column of Table 1 and provide the converted standard from those results.[2] Please list the group below (e.g., pregnant women) and an explanation of why the SIPP results are being used for this eligibility group (e.g., data unavailable). Attach additional pages if necessary. Note that for groups that need to be converted both for eligibility and FMAP purposes (e.g,. childless adults) the same income conversion method/data source (i.e., SIPP or state data) must be used.

Maryland is using state data for coverage groups where data is reliable, available, and where it will have an impact on our Medicaid program after January 1, 2014. These groups are children ages 1 to 5, optional reasonable classifications of individuals under age 21, and parents under section 1931. For all other groups, Maryland is using SIPP results. The following groups will be converted using SIPP data:

- Pregnant women, full benefits – The sample size in our P11 coverage group (pregnant women 200% FPL – 250% FPL) only contains approximately 500 enrollees in any given month. Due to the small sample size and concerns about reliability, we will be using SIPP data.
- Family planning services – Maryland's Family Planning eligibility system of record is outside of CARES and the data was not readily available.
- Other Medicaid section 1115 demonstration (e.g., childless adults) – Maryland's childless adult (Primary Adult Care program or PAC) system of record is outside of CARES and the data was not readily available. Also, because Maryland will be expanding, all

[2] If SIPP results include conversions for applicants and beneficiaries, both should be included.

of these childless adults will be considered newly eligible beginning January 1, 2014. This conversion will not have an impact on the Maryland Medicaid program.

- AFDC payment standard 7/16/1996 – While this data is available in our CARES system, this conversion will not have an impact on the Maryland Medicaid program because Maryland currently covers parents up to 116% FPL.
- Children under age 1, children ages 6 to 18, M-CHIP optional targeted low-income children (non-premium) & M-CHIP premium – Due to significant differences with the results from our state data conversion and the SIPP results, SIPP data will be used.

For all conversions using state data, please provide the following information:

Time period-Specify the time period of data that was used, for example, June 2011-May 2012. If a time period other than 12 months was used, please explain why below and summarize the methods used to determine that the time period is unbiased. Attach additional pages if necessary:

A full year of data were used for all conversions (January 2012 – December 2012).

Sampling: Please mark this column yes or no. If yes (in other words, the analysis did not include all records in the eligibility group), please provide a detailed explanation below of the sampling approach that was used (i.e., simple random sample, stratified sample, etc.). Please also provide information about the total population and the number of records sampled. Attach additional pages if necessary.

Net income standard- Please fill in the net standard that was converted for each eligibility group. This should reflect the bolded standard from the eligibility template that you developed with CMS. For conversions that were based on fixed dollar thresholds, please specify the net standard for each family size. You may use fewer or more family sizes than indicated in Table 1.

For 1115 demonstrations, please enter a row for each MAGI-included 1115 demonstration group, specifying whether its Medicaid or S-CHIP.

Income band used in conversion-This column is applicable only for the State Data method and should reflect the net standard minus 25 percentage points of FPL. For example, if the net standard was 120% FPL, the income band used in conversion would be 95% FPL to 120% FPL. For standards at or below 25% FPL, the income band will include all records—e.g., for a net standard of 18% FPL, the

income band used in conversion should be 0-18% FPL. For conversions of <u>fixed dollar thresholds</u> , please specify the income band (expressed as a percentage of FPL) for each family size. [3]

<u>Converted standard for applicants</u>-Please fill in the converted standard for applicants. Fixed dollar standards should be given in dollars for each family size.

<u>Converted standard for beneficiaries (if relevant)</u>- If your state applies different disregards based on whether someone is applying or being renewed for coverage, and you are doing a separate conversion for beneficiaries, please provide. Fixed dollar standards should be given in dollars for each family size.

<u>Special note for premium payment groups</u>: if your state charges premiums for any eligibility group, you will need to attach a separate sheet showing the MAGI Conversion Plan information requested for each income level used to determine premium payments.

[3] See page 15 of *How States Can Implement the Standardized Modified Adjusted Gross Income (MAGI) Conversion Methodology from State Medicaid and CHIP Data* for more information on converting fixed dollar standards to FPL. <u>http://aspe.hhs.gov/health/reports/2013/MAGIHowTo/rb.cfm</u>.

Table 1

Coverage Category	SIPP Results used (Yes/No)	Time Period	Sampling (yes/no)	Net Income Standard	(For State Data Method Only) Income band used in conversion	Converted Standard for Applicants	Converted Standard for Beneficiaries (if relevant)
Parents and other caretaker relatives (mandatory under Section 1931)	No	CY 2012, January to December	No	% FPL 116%	% FPL 91% to 116%	% FPL 123%	N/A
Parents and other caretaker relatives (optional under 1902(a)(10)(A)(ii)(I)	N/A	N/A	N/A			N/A	N/A
Pregnant women, full benefits	Yes			% FPL 250%		% FPL 259%	N/A
Pregnant women, pregnancy only coverage	N/A	N/A	N/A			N/A	N/A
Children under age 1	Yes			% FPL 185%	%FPL	%FPL 194%	N/A
Children ages 1 to 5	No	CY 2012, January to December	No	%FPL 133%	%FPL 108% to 133%	%FPL 138%	N/A
Children ages 6 to 18	Yes			%FPL 100%	%FPL	%FPL 109%	N/A
M-CHIP optional targeted low-income children (non-premium)	Yes			%FPL 185% to 200% FPL		% FPL 211%	N/A
Optional reasonable classifications of individuals under age 21	No	CY 2012, January to December	No	% FPL 116%	% FPL 91% to 116%	% FPL 123%	N/A
State adoption assistance	N/A	N/A	N/A			N/A	N/A

Coverage Category	SIPP Results used (Yes/No)	Time Period	Sampling (yes/no)	Net Income Standard	(For State Data Method Only) Income band used in conversion	Converted Standard for Applicants	Converted Standard for Beneficiaries (if relevant)
Independent foster care adolescents	N/A	N/A	N/A			N/A	N/A
Family planning services	Yes			%FPL 200%		% FPL 212%	N/A
Individuals needing TB-related services	N/A					N/A	N/A
Other Medicaid section 1115 demonstration (e.g., childless adults)	Yes			Childless adults, 116% FPL		% FPL 123%	N/A
Separate CHIP • Children	N/A	N/A	N/A			N/A	N/A
Separate CHIP • Pregnant Women	N/A	N/A	N/A			N/A	N/A
Separate CHIP • Unborn child option	N/A	N/A	N/A			N/A	N/A
AFDC payment standard 5/1/1988	N/A	N/A	N/A	Fixed dollar standards Family size 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ Add-on for additional family members if relevant_____	% FPL by family size 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ Add-on for additional family members if relevant_____	Fixed dollar standards Family size 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ Add-on for additional family members if relevant_____	Fixed dollar standards Family size 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ Add-on for additional family members if relevant_____

Coverage Category	SIPP Results used (Yes/No)	Time Period	Sampling (yes/no)	Net Income Standard	(For State Data Method Only) Income band used in conversion	Converted Standard for Applicants	Converted Standard for Beneficiaries (if relevant)
AFDC payment standard 7/16/1996	Yes			Fixed dollar standards Family size 1 $165 2 $292 3 $373 4 $450 5 $521 6 $573 7 $645 8 $709 9 $766 10 $826 11 $886 12 $946 13 $1,004 14 $1,063 15 $1,124 16$1,184 Add-on for additional family members if relevant $61	% FPL _____ **or** % FPL by Family size (for groups with fixed dollar standards) 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ Add-on for additional family members if relevant_____	Fixed dollar standards Family size 1 $187 2 $322 3 $410 4 $495 5 $574 6 $633 7 $713 8 $785 9 $849 10 $917 11 $984 12 $1,052 13 $1,118 14 $1,184 15 $1,253 16 $1,321 Add-on for additional family members if relevant $68.70	Fixed dollar standards Family size 1 N/A 2 N/A 3 N/A 4 N/A 5 N/A 6 N/A 7 N/A 8 N/A 9 N/A 10 N/A 11 N/A 12 N/A 13 N/A 14 N/A 15 N/A 16 N/A Add-on for additional family members if relevant N/A
Premium payment determination	**PLEASE ATTACH A SEPARATE SHEET SHOWING REQUESTED INFORMATION FOR EACH RELEVANT INCOME LEVEL USED TO DETERMINE PREMIUM PAYMENTS**						

Coverage Category	SIPP Results used (Yes/No)	Time Period	Sampling (yes/no)	Net Income Standard	(For State Data Method Only) Income band used in conversion	Converted Standard for Applicants	Converted Standard for Beneficiaries (if relevant)
Pre-CHIP Medicaid as of 3/31/97	Yes (<1, 6-18) State data used for 1-5	CY 2012, January to December	No	< age 1: 185% 1-5: 133% 6-13: 100% 14-18: 100%	1-5: 108-133%	< age 1: 194% 1-5: 138% 6-13: 109% 14-18: 109%	N/A
Premium Payment Determination M-CHIP, 200 to 250% FPL M-CHIP, 251 to 300% FPL	Yes			200% FPL to 250% FPL 251 to 300% FPL		Lower bound: 212% FPL Middle bound: 264% FPL Upper bound: 317% FPL Resulting bands: 212 to 264% FPL; 265 to 317% FPL	N/A

PART 1: ELIGIBILITY CONVERSIONS

Alternative Method, additional information

Please provide a summary of the alternative method and data source or sources used for income conversion, including how the method differs from the Standardized MAGI Conversion Methodology specified in the December 28, 2012 State Health Officials' Letter on Modified Adjusted Gross Income (MAGI) Income Conversion. Please include equations showing how the method is applied mathematically and a description of how fixed dollar standards were converted, if relevant. Attach additional pages if necessary.

Please provide a description below of how your method meets the criteria specified in the December 28, 2012 State Health Officials' Letter on Modified Adjusted Gross Income (MAGI) Conversion: unbiased, accuracy, precision, and data quality. Attach additional pages if necessary. More detailed information about these criteria is available in the ASPE issue brief *Modified Adjusted Gross Income (MAGI) Income Conversion Methodologies.*[4]

Unbiased: Across all eligibility categories, the method does not systematically increase or decrease the number of eligible individuals within a given eligibility group or systematically increase or decrease the costs to states.

Accuracy: To the extent possible, the method minimizes changes in eligibility status by minimizing losses and gains in eligibility for a given category of coverage.

[4] See http://www.shadac.org/files/2.%20ASPE%20Brief%20-%20MAGI%20Income%20Conversion%20Methodologies%20(March%202013).pdf.

Precision: The converted standard must be stable and repeatable. In other words, if the methodology to arrive at the converted standard were repeated, it would arrive at the same result. For example, if a sampling methodology is used, the sample size must be large enough to ensure that the conversion method, if calculated on another sample, would in general yield the same converted standard.

Data quality: The data used are representative of the income and disregards of the population so as not to bias the converted standard due to poor data quality.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

AFDC Income Standards S14

Enter the AFDC Standards below. All states must enter:

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988 and
AFDC Payment Standard in Effect As of July 16, 1996

Entry of other standards is optional.

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- (●) Statewide standard
- ( ) Standard varies by region
- ( ) Standard varies by living arrangement
- ( ) Standard varies in some other way

Enter the statewide standard

	Household size	Standard ($)	
+	1	187	X
+	2	322	X
+	3	410	X
+	4	495	X
+	5	574	X
+	6	633	X
+	7	713	X
+	8	785	X
+	9	849	X
+	10	917	X
+	11	984	X
+	12	1,052	X
+	13	1,118	X
+	14	1,184	X
+	15	1,253	X
+	16	1,321	X

Additional incremental amount

(•) Yes ( ) No

Increment amount $ 68.7

The dollar amounts increase automatically each year

( ) Yes (•) No

AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

(•) Statewide standard

( ) Standard varies by region

○ Standard varies by living arrangement

○ Standard varies in some other way

Enter the statewide standard

	Household size	Standard ($)	
+	1	165	X
+	2	292	X
+	3	373	X
+	4	450	X
+	5	521	X
+	6	573	X
+	7	645	X
+	8	709	X
+	9	766	X
+	10	826	X
+	11	886	X
+	12	946	X
+	13	1,004	X
+	14	1,063	X
+	15	1,124	X
+	16	1,184	X

Additional incremental amount

◉ Yes ○ No

Increment amount $ 61

The dollar amounts increase automatically each year

○ Yes ◉ No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option $13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

AFDC Need Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date.

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

MAGI-equivalent TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Presumptive Eligibility by Hospitals S21

42 CFR 435.1110

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

◉ Yes ○ No

☑ The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

■ A qualified hospital is a hospital that:

■ Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

■ Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

Assists individuals in completing and submitting the full application and understanding any documentation requirements.

◉ Yes ○ No

■ The eligibility groups or populations for which hospitals determine eligibility presumptively are:

■ Pregnant Women

■ Infants and Children under Age 19

■ Parents and Other Caretaker Relatives

■ Adult Group, if covered by the state

■ Individuals above 133% FPL under Age 65, if covered by the state

■ Individuals Eligible for Family Planning Services, if covered by the state

■ Former Foster Care Children

■ Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state

☐ Other Family/Adult groups:

☐ Eligibility groups for individuals age 65 and over

☐ Eligibility groups for individuals who are blind

☐ Eligibility groups for individuals with disabilities

☐ Other Medicaid state plan eligibility groups

☐ Demonstration populations covered under section 1115

The state establishes standards for qualified hospitals making presumptive eligibility determinations.

Medicaid Eligibility

◉ Yes ○ No

Select one or both:

☒ The state has standards that relate to the proportion of individuals determined presumptively eligible who submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Description of standards:

1) 90 percent of all approved HPE applicants submit a full MA application no later than the last day of the month following the month during which the HPE determination is made
2) 90 percent of the time the Hospital's determination that applicants did not receive temporary coverage within the past 12 months is correct.
3) 90 percent of the time the Hospital's determination that the applicants do not have current Medicaid/CHIP is correct

☐ The state has standards that relate to the proportion of individuals who are determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

■ The presumptive period begins on the date the determination is made.

■ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

■ Periods of presumptive eligibility are limited as follows:

○ No more than one period within a calendar year.

○ No more than one period within two calendar years.

◉ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

○ Other reasonable limitation:

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

◉ Yes ○ No

○ The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

◉ The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

Medicaid Eligibility

■ The presumptive eligibility determination is based on the following factors:

■ The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)

■ Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.

☒ State residency

☒ Citizenship, status as a national, or satisfactory immigration status

☑ The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Parents and Other Caretaker Relatives **S25**

42 CFR 435.110
1902(a)(10)(A)(i)(I)
1931(b) and (d)

■ **Parents and Other Caretaker Relatives** - Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.

The state elects the following options:

☒ This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.

☐ Options relating to the definition of caretaker relative (select any that apply):

☒ Options relating to the definition of dependent child (select the one that applies):

◉ The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.

○ The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):

■ Have household income at or below the standard established by the state.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for this group

■ Minimum income standard

The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.

☑ The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

An attachment is submitted.

■ Maximum income standard

Medicaid Eligibility

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

○ The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

◉ The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

◉ A percentage of the federal poverty level: 123 %

○ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ Other dollar amount

■ Income standard chosen:

Indicate the state's income standard used for this eligibility group:

○ The minimum income standard

◉ The maximum income standard

○ The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14 AFDC Income Standards.

○ Another income standard in-between the minimum and maximum standards allowed

■ There is no resource test for this eligibility group.

■ Presumptive Eligibility

Medicaid Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

○ Yes ◉ No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

State Name: Maryland

OMB Control Number: 0938-1148

Transmittal Number: MD - 17 - 0003

Eligibility Groups - Mandatory Coverage
Pregnant Women

S28

42 CFR 435.116
1902(a)(10)(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

■ **Pregnant Women -** Women who are pregnant or post-partum, with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 CFR 435.110.

◉ Yes ○ No

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for this group

■ Minimum income standard (Once entered and approved by CMS, the minimum income standard cannot be changed.)

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

○ Yes ○ No

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

○ The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

- (●) The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- ( ) The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.
- ( ) The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
- ( ) 185% FPL

The amount of the maximum income standard is: [ ] % FPL

■ Income standard chosen

Indicate the state's income standard used for this eligibility group:

- ( ) The minimum income standard
- (●) The maximum income standard
- ( ) Another income standard in-between the minimum and maximum standards allowed.

■ There is no resource test for this eligibility group.

■ Benefits for individuals in this eligibility group consist of the following:

- (●) All pregnant women eligible under this group receive full Medicaid coverage under this state plan.
- ( ) Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women receive only pregnancy-related services.

■ Presumptive Eligibility

The state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a qualified entity.

(●) Yes ( ) No

■ The presumptive period begins on the date the determination is made.

■ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

■ There may be no more than one period of presumptive eligibility per pregnancy.

A written application must be signed by the applicant or representative.

Medicaid Eligibility

(●) Yes ( ) No

( ) The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

(●) The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

[■] The presumptive eligibility determination is based on the following factors:

[■] The woman must be pregnant

[■] Household income must not exceed the applicable income standard at 42 CFR 435.116.

[☒] State residency

[☒] Citizenship, status as a national, or satisfactory immigration status

[■] The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

List of Qualified Entities S17

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

[ ] Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan

[ ] Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act

[ ] Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990

[ ] Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966

[ ] Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)

[ ] Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)

[ ] Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs

[ ] Is a state or Tribal child support enforcement agency under title IV-D of the Act

[ ] Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act

[ ] Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act

☐ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)

☐ Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization

☒ Other entity the agency determines is capable of making presumptive eligibility determinations:

	Name of entity	Description	
+	State & Local Correctional Facilities	State facilities under the direction of the Maryland Department of Public Safety and Correctional Services (DPSCS) and local detention centers within the State's 24 local jurisdictions.	x

☑ The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and has provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

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V.20160722

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Infants and Children under Age 19 **S30**

42 CFR 435.118
1902(a)(10)(A)(i)(III), (IV), (VI) and (VII)
1902(a)(10)(A)(ii)(IV) and (IX)
1931(b) and (d)

■ **Infants and Children under Age 19 -** Infants and children under age 19 with household income at or below standards established by the state based on age group.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Children qualifying under this eligibility group must meet the following criteria:

■ Are under age 19

■ Have household income at or below the standard established by the state.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for infants under age one

■ Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.

◉ Yes ○ No

Enter the amount of the minimum income standard (no higher than 185% FPL): 185 % FPL

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for infants under age one to MAGI-equivalent standards and the determination of the maximum income standard to be used for infants under age one.

An attachment is submitted.

The state's maximum income standard for this age group is:

◉ The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ 185% FPL

Enter the amount of the maximum income standard: 194 % FPL

■ Income standard chosen

The state's income standard used for infants under age one is:

◉ The maximum income standard

○ If not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

■ Income standard for children age one through age five, inclusive

■ Minimum income standard

The minimum income standard used for this age group is 133% FPL.

☑ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for children age one through five to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age one through five.

An attachment is submitted.

The state's maximum income standard for children age one through five is:

◉ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Enter the amount of the maximum income standard: 138 % FPL

☑ Income standard chosen

The state's income standard used for children age one through five is:

◉ The maximum income standard

○ If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

■ Income standard for children age six through age eighteen, inclusive

■ Minimum income standard

The minimum income standard used for this age group is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for children age six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.

An attachment is submitted.

The state's maximum income standard for children age six through eighteen is:

○ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

◉ 133% FPL

■ Income standard chosen

The state's income standard used for children age six through eighteen is:

Medicaid Eligibility

◉ The maximum income standard

If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), ○ 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children ○ age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children ○ age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children ○ age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

■ There is no resource test for this eligibility group.

■ Presumptive Eligibility

The state covers children when determined presumptively eligible by a qualified entity.

○ Yes ◉ No

PRA Disclosure Statement

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Medicaid Eligibility

State Name: Maryland

OMB Control Number: 0938-1148

Transmittal Number: MD - 17 - 0003

Eligibility Groups - Mandatory Coverage
Adult Group

S32

1902(a)(10)(A)(i)(VIII)
42 CFR 435.119

The state covers the Adult Group as described at 42 CFR 435.119.

◉ Yes ○ No

■ **Adult Group -** Non-pregnant individuals age 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ Have attained age 19 but not age 65.

■ Are not pregnant.

■ Are not entitled to or enrolled for Part A or B Medicare benefits.

■ Are not otherwise eligible for and enrolled for mandatory coverage under the state plan in accordance with 42 CFR 435, subpart B.

Note: In 209(b) states, individuals receiving SSI or deemed to be receiving SSI who do not qualify for mandatory Medicaid eligibility due to more restrictive requirements may qualify for this eligibility group if otherwise eligible.

■ Have household income at or below 133% FPL.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ There is no resource test for this eligibility group.

■ Parents or other caretaker relatives living with a child under the age specified below are not covered unless the child is receiving benefits under Medicaid, CHIP or through the Exchange, or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

○ Under age 19, or

◉ A higher age of children, if any, covered under 42 CFR 435.222 on March 23, 2010:

○ Under age 20

◉ Under age 21

■ Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

◉ Yes ○ No

☑ The presumptive period begins on the date the determination is made.

☑ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

☑ Periods of presumptive eligibility are limited as follows:

- ○ No more than one period within a calendar year.
- ○ No more than one period within two calendar years.
- ◉ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.
- ○ Other reasonable limitation:

The state requires that a written application be signed by the applicant or representative.

◉ Yes ○ No

- ○ The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.
- ◉ The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

☑ The presumptive eligibility determination is based on the following factors:

- ☑ The individual must meet the categorical requirements of 42 CFR 435.119.
- ☑ Household income must not exceed the applicable income standard described at 42 CFR 435.119.
- ☒ State residency.
- ☒ Citizenship, status as a national, or satisfactory immigration status.

☑ The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

List of Qualified Entities S17

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

- ☐ Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan
- ☐ Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act

Medicaid Eligibility

- ☐ Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990
- ☐ Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966
- ☐ Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)
- ☐ Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)
- ☐ Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs
- ☐ Is a state or Tribal child support enforcement agency under title IV-D of the Act
- ☐ Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act
- ☐ Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act
- ☐ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)
- ☐ Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization
- ☒ Other entity the agency determines is capable of making presumptive eligibility determinations:

	Name of entity	Description	
+	State & Local Correctional Facilities	State facilities under the direction of the Maryland Department of Public Safety and Correctional Services (DPSCS) and local detention centers within the State's 24 local jurisdictions.	x

☑ The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and has provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

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V.20160722

Medicaid Eligibility

State Name: Maryland

OMB Control Number: 0938-1148

Transmittal Number: MD - 17 - 0003

Eligibility Groups - Mandatory Coverage **Former Foster Care Children**	**S33**

42 CFR 435.150
1902(a)(10)(A)(i)(IX)

■ **Former Foster Care Children** - Individuals under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and in foster care when they turned age 18 or aged out of foster care.

☑ The state attests that it operates this eligibility group under the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ Are under age 26.

■ Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

■ Were in foster care under the responsibility of the state or Tribe and were enrolled in Medicaid under the state's state plan or 1115 demonstration when they turned 18 or at the time of aging out of that state's or Tribe's foster care program.

The state elects to cover children who were in foster care and on Medicaid in any state at the time they turned 18 or aged out of the foster care system.

○ Yes ◉ No

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

◉ Yes ○ No

■ The presumptive period begins on the date the determination is made.

■ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

■ Periods of presumptive eligibility are limited as follows:

○ No more than one period within a calendar year.

○ No more than one period within two calendar years.

◉ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

○ Other reasonable limitation:

	Name of limitation	Description	
+			X

The state requires that a written application be signed by the applicant or representative.

(•) Yes ( ) No

( ) The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

(•) The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

[■] The presumptive eligibility determination is based on the following factors:

[■] The individual must meet the categorical requirements of 42 CFR 435.150.

[☒] State residency

[☒] Citizenship, status as a national, or satisfactory immigration status

[■] The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

List of Qualified Entities **S17**

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

[ ] Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan

[ ] Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act

[ ] Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990

[ ] Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966

[ ] Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)

[ ] Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)

[ ] Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs

[ ] Is a state or Tribal child support enforcement agency under title IV-D of the Act

[ ] Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act

Medicaid Eligibility

☐ Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act

☐ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)

☐ Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization

☒ Other entity the agency determines is capable of making presumptive eligibility determinations:

	Name of entity	Description	
+	State & Local Correctional Facilities	State facilities under the direction of the Maryland Department of Public Safety and Correctional	X

☑ The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and has provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

STATE OF MARYLAND
DHMH

APPLICATION FOR PRESUMPTIVE (TEMPORARY) ELIGIBILITY FOR MEDICAL ASSISTANCE

PART I – INFORMATION REQUIRED FOR DETERMINATION

(Items marked with an * are required for determination.)

Legal Name:			
First*:	Middle:	Last*:	Suffix:
Family Size*:	Household Gross Monthly Income*:		Maryland Resident?* ❑ Yes ❑ No
U.S. Citizen, U.S. National or Eligible Non-Citizen?* ❑ Yes ❑ No			
If readily available, also tell us the following (optional):			
Are you pregnant? ❑ Yes ❑ No	If yes, what is your due date?	How many babies are you expecting?	
Other Insurance Coverage? ❑ Yes ❑ No	In Foster Care at age 18? ❑ Yes ❑ No	Already have Medicaid? ❑ Yes ❑ No	Already have Medicare? ❑ Yes ❑ No

PART II – PRESUMPTIVE DETERMINATION: Representative must make the determination based on the REQUIRED information in Part I only and give the applicant an approval or denial notice.

Eligible? ❑ Yes ❑ No	If yes, select the eligibility group: ❑ Adult ❑ Pregnant Woman ❑ Former Foster Youth <26

PART III – INFORMATION NECESSARY TO ENTER THIS APPLICATION

Contact Information			
Home Address:			
City:	State:	Zip Code:	County:
Mailing Address (if different from Home):			
City:	State:	Zip Code:	County:
Phone Number:			
Home:	Work:	Cell:	
Additional Information			
Date of Birth: / /	Social Security Number (optional):		Sex: ❑ Male ❑ Female

PART IV - SIGNATURES

Applicant: By signing, you are attesting that the information you provided for this form is true as far as you know and that you have received a copy of the Approval Notice that lists your Rights and Responsibilities, or a Denial Notice. We will keep your information secure and private.

Signature of Applicant (or legal guardian) _____ Date _____

Signature of Witness (or legal guardian) _____ Date _____

Representative: By signing, you are attesting that you have accurately recorded the information provided by the applicant or someone representing the applicant, made a determination based on that information, and provided the applicant with an Approval Notice that lists their Rights and Responsibilities or a Denial Notice.

Signature of Applicant (or legal guardian) _____ Date _____

Signature of Witness (or legal guardian) _____ Date _____

Presumptive Eligibility (PE) Worksheet

(For use by PE Worker)

Name of Applicant: _____

Name of PE Worker: _____

Check the Eligibility Verification System (EVS) to make sure the applicant is not already enrolled with Medicaid. Include the applicant's Social Security Number when/if provided.

(Circle One)

1. Did EVS report any findings for the applicant's information? Yes No

   If YES, generally you should STOP. (The only exception is if EVS indicates that the applicant has Family Planning Coverage only. In this case, you may continue to question 2. Otherwise, STOP.)
   If NO, continue to question 2.

2. Does the applicant have active Medicare? Yes No

   If YES, STOP only if the applicant falls under the Adult eligibility group. (For Pregnant Women or Former Foster Children up to age 26, you may continue to question 3.)
   If NO, continue to question 3.

3. Is the applicant a Maryland resident? Yes No

   If NO, STOP. The applicant is not eligible for PE.
   If YES, continue to question 4.

4. Has the applicant declared that he/she is a U.S. Citizen, U.S. National, or Eligible Non-Citizen (Refer to Page 2 for guidance)? Yes No

   If NO, STOP. The applicant is not eligible for PE.
   If YES, continue to question 5.

5. Is the applicant 65 years of age or older? Yes No

   If YES, STOP. The applicant is not eligible for PE. However, refer the applicant to the Department of Social Services to complete a full application.
   If NO, continue to question 6 Family Size and Income Level eligibility guide below.

Eligible Non-Citizens include:

- Lawful Permanent Residents (LPRs or "green card" aliens) who entered the U.S. before 8/22/1996 or who have been in a qualified status for more than 5 years
  - LPRs that have adjusted from a status that is exempt from a 5-year waiting period are not subject to the 5-year waiting period regardless of the date of entry
- Aliens paroled into U.S. for at least 1 year (subject to 5-year waiting period)
- Aliens admitted as battered spouse, child or parent (subject to 5-year waiting period)
- Asylees
- Refugees
- Cuban/Haitian entrants
- Amerasians born to U.S. armed services members in Southeast Asia during Vietnam War
- Individuals with Iraqi or Afghan special immigrant status
- Members of a federally recognized Indian tribe or American Indian born in Canada
- Aliens granted With-holding of Deportation or Removal (unsafe to return to country)
- Aliens granted Conditional Entrant status before 1980
- Victim of trafficking and spouse, child, sibling or parent
- Alien veteran of active- duty U.S. military and spouse or un-remarried surviving spouse, and children
- Children under 21 and pregnant women *lawfully present* in the US

The following individuals are considered *lawfully present*:

- All qualified non-citizens (as defined on slides 7 and 8)
- A non-citizen in valid non-immigrant status (for example, student visas, worker visas, etc.)
- A non-citizen who has been paroled into the United States, for less than 1 year, except for a non-citizen paroled for prosecution, deferred inspection or pending removal proceedings
- A non-citizen who belongs to one of the following classes:
  - Non-citizens currently in temporary resident status
  - Non-citizens currently under Temporary Protected Status (TPS) (and pending applicants for TPS who have been granted employment authorization
  - Non-citizens who have been granted employment authorization;
  - Family Unity beneficiaries
  - Non-citizens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President
  - Non-citizens currently in deferred action status (note that this does not include individuals with DACA granted under the June 2012 DHS Policy [Deferred Action for Childhood Arrivals] status
  - Granted an administrative stay of removal
  - Non-citizens whose visa petition has been approved and who have a pending application for adjustment of status.
- A pending applicant for asylum or for withholding of removal or under the Convention Against Torture who has been granted employment authorization, or is an applicant under the age of 14 and has had an application pending for at least 180 days
- A non-citizen who has been granted withholding of removal under the Convention Against Torture
- A child who has a pending application for Special Immigrant Juvenile status;
- A non-citizen who is lawfully present in American Samoa under the immigration laws of American

Income and Family Size Assessment

List the gross income (earned and unearned) for the following individuals living together:

Family Size	Family Member	Weekly	Bi-weekly	Monthly	Mark "X" if this Person is employed
1	Applicant	$ X4	$ X2	$	
2		$ X4	$ X2	$	
3					
4					

Total Monthly Income: $_____

Circle Applicant's Family Size and Income Level below:

Notes:

- A pregnant woman's family size should always be at least 2 – herself and her unborn child.
- There are no income limits for former foster care children up to age 26 years old

2017 Monthly Income Limits

Family Size	Adults 19 < 65 ≤ 138%	Pregnant Women ≤ 264%
1	$1,386	-
2	$1,868	$3,574
3	$2,348	$4,493
4	$2,829	$5,412
5	$3,310	$6,333
6	$3,790	$7,252
7	$4,271	$8,170
8	$4,752	$9,092

2017 Annual Income Limits

Family Size	Adults 19 < 65 ≤ 138%	Pregnant Women ≤ 264%
1	$16,643	-
2	$22,411	$42,055
3	$28,180	$53,038
4	$33,948	$64,020
5	$39,716	$75,002
6	$45,485	$85,985
7	$51,253	$96,967
8	$57,022	$107,950

6. Is the applicant's income at or below the amount listed for the family size? Yes No

   If NO, STOP. The applicant is not eligible for PE. Do not enter the application into eMedicaid.
   If YES, please circle which MAGI group the applicant classifies as:
   - Adult
   - Former Foster Care at any age prior to 26
   - Pregnant woman

You will need to include this eligibility group within the PE application. Proceed to PE eMedicaid portal/manual. Follow instructions for PE eMedicaid information input.

CHANGING Maryland *for the Better*

Presumptive Eligibility Training

For State and Local Correctional Facilities

Agenda

Today's training will cover:

- Understanding PE as a program
- Becoming a PE worker
- How to make PE eligibility determinations
- Notifying the PE applicant of the result of the PE determination

Understanding PE

What is PE?

What is Presumptive Eligibility (PE)?

- PE allows "qualified entities" to temporarily enroll individuals into Medicaid based on basic, self-attested income and demographic information

Most recently, Maryland has expanded its program to include state and local correctional facilities as "qualified entities" to conduct PE

- PE determination may only be conducted by certified PE workers within these facilities

What is the Purpose of PE?

Presumptive Eligibility enables:

- Timely access to necessary health care services;
- Temporary medical coverage while full eligibility is being determined; and
- A pathway to longer-term Medicaid coverage, based on minimum eligibility information

Must attempt to complete the full MA application <u>prior to</u> submitting a PE application.

Who is Eligible for PE?

Under the Affordable Care Act (ACA), Modified Adjusted Gross Income (MAGI) populations are eligible for PE.

They include:

- Adults through 138% FPL,
- Pregnant women through 264% FPL;
- Individuals up to and including age 26 formerly in Foster Care in Maryland, no FPL limit.

Who is Eligible for PE?

In addition, individuals must be Maryland residents and either a US Citizen or Eligible Non-Citizen to qualify for PE.

Eligible Non-Citizens include:

- Lawful Permanent Residents (LPRs or "green card" aliens) who entered the U.S. before 8/22/1996 or who have been in a qualified status for more than 5 years;
  - LPRs that have adjusted from a status that is exempt from a 5-year waiting period are not subject to the 5-year waiting period regardless of the date of entry
- Aliens paroled into U.S. for at least 1 year (subject to 5-year waiting period); and
- Aliens admitted as battered spouse, child or parent (subject to 5-year waiting period).

Who is Eligible for PE?

Eligible Non-Citizens also include:

- Asylees;
- Refugees;
- Cuban/Haitian entrants;
- Amerasians born to U.S. armed services members in Southeast Asia during Vietnam War;
- Individuals with Iraqi or Afghan special immigrant status;
- Members of a federally recognized Indian tribe or American Indian born in Canada;
- Aliens granted With-holding of Deportation or Removal (unsafe to return to country);
- Aliens granted Conditional Entrant status before 1980;
- Victim of trafficking and spouse, child, sibling or parent; and
- Alien veteran of active- duty U.S. military and spouse or un-remarried surviving spouse, and children.

Who is Eligible for PE?

Children under 21 and pregnant women lawfully present in the U.S. are also eligible for PE.

The following individuals are considered lawfully present:

- All qualified non-citizens (listed on slides 7 and 8);
- A non-citizen in valid non-immigrant status (for example, student visas, worker visas, etc.);
- A non-citizen who has been paroled into the United States, for less than 1 year, except for a non-citizen paroled for prosecution, deferred inspection or pending removal proceedings;
- A pending applicant for asylum or for withholding of removal or under the Convention Against Torture who has been granted employment authorization, or is an applicant under the age of 14 and has had an application pending for at least 180 days;
- A non-citizen who has been granted withholding of removal under the Convention Against Torture;
-

Who is Eligible for PE?

The following individuals are considered lawfully present (cont.):

- A child who has a pending application for Special Immigrant Juvenile status;
- A non-citizen who is lawfully present in American Samoa under the immigration laws of American; and
- A non-citizen who belongs to one of the following classes:
  - Non-citizens currently in temporary resident status
  - Non-citizens currently under Temporary Protected Status (TPS) (and pending applicants for TPS who have been granted employment authorization
  - Non-citizens who have been granted employment authorization;
  - Family Unity beneficiaries
  - Non-citizens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President
  - Non-citizens currently in deferred action status (note that this does not include individuals with DACA granted under the June 2012 DHS Policy [Deferred Action for Childhood Arrivals] status
  - Granted an administrative stay of removal
  - Non-citizens whose visa petition has been approved and who have a pending application for

What Does PE Offer Enrollees?

PE enrollees are entitled to temporary Medicaid benefits.

However, it is important for PE enrollees to complete the full MA application.

- PE enrollees do not enroll in HealthChoice managed care organizations (MCO) until found eligible for full MA
- Maryland Medicaid offers a full set of benefits through its MCOs for full MA enrollees

What Does PE Mean for the Incarcerated?

Eligibility:

- Incarcerated individuals within Maryland's state and local correctional facilities that fall within a MAGI eligibility group are eligible for PE.

Benefits:

- PE approved individuals may begin to receive Medicaid benefits within the PE period only upon release.

What Does PE Offer Providers?

Medicaid can reimburse providers for services rendered to PE enrollees during the temporary PE coverage period.

- However, services rendered to PE enrollees must meet all applicable MA requirements, including any preauthorization and utilization review

What is the Length of PE Coverage?

PE coverage begins..

- The day PE determination is made.

PE coverage ends the earlier of the two…..

- The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the end of the last day of the month following the month in which the determination of PE is made; or
- The last day of the month following the month in which the PE worker makes the PE determination, if the individual does not file a full application.

How often can someone have PE Coverage?

The PE coverage span depends on the PE coverage group:

- Individuals are permitted only one PE coverage span in a 12-month period.
- Pregnant women are permitted only one PE coverage span per pregnancy.
- This is calculated from the last day of the most recent prior PE coverage span.

Becoming a PE Worker

Who can be a PE Worker?

PE workers must be certified government employees in order to make PE determinations. PE workers may be employees of:

- Department of Health and Mental Hygiene;
- Department of Public Safety and Correctional Services;
- Local Detention Centers; and
- Local Health Departments.

Contractual workers are not eligible to become PE workers.

What is a PE Worker's Role?

PE workers are the PE program's gatekeepers. They:

- Identify individuals eligible for Medicaid coverage;
- Screen individuals through EVS to ensure they do not already have Medicaid coverage;
- Assist in completing the full MA application, when possible;
- If a full MA application is not possible, conduct presumptive eligibility determination for individuals;
- Enter the PE application information into the PE eMedicaid portal;
  - Self-attestation is sufficient to verify information required to make a PE determination.

What is a PE Worker's Role?

PE workers are responsible for educating PE enrollees that:

- Individuals are only eligible for PE coverage once over a 12-month period;
- Full Medicaid benefits are available to approved PE applicants;
  - except pregnant women, where PE benefits are limited to ambulatory pre-natal care;
- PE Approval Notice is the ONLY PROOF OF INSURANCE; and
- A full MA application should be completed before PE coverage ends.

How do I become a PE worker?

In order to be a PE worker, one must:

- Complete this webinar training;
- Take the PE Knowledge Test; and
- Achieve 80 percent or higher on PE Knowledge Test to pass.

Once completed, the Department will grant PE workers access to the PE eMedicaid Portal.

Making PE Determinations

How Do You Make PE Determinations?

Hand-off to PE Worker

- An eligibility worker may not be able to complete a full MA application for a Medicaid-eligible inmate for many reasons. If this occurs, the eligibility worker will conduct a PE determination if they are PE-certified or refer the individual to a PE worker.

PE workers are to conduct the following activities for each PE determination:

- Check EVS for current MA eligibility and prior PE period;
- Gather basic eligibility information from the PE applicant;
- Complete the PE worksheet and PE application;
- Submit the PE application through the PE eMedicaid portal;
- Notify the applicant of their PE determination;
- Further educate the PE enrollee about PE; and
- Follow up with the PE applicant in completing the full MA application, when possible.

Making PE Determinations: EVS

Check the Medicaid Eligibility Verification System (EVS)

- Participating correctional facilities may check web EVS via eMedicaid at emdhealthchoice.org
- If the applicant has current MA coverage, they are ineligible for PE
  - However, a PE applicant that only receives Family Planning coverage is eligible, because PE provides a richer benefits package

Making PE Determinations: Eligibility

Gather eligibility information. Family size and gross income are key to determining PE eligibility

- Collect the PE applicant's monthly gross household income; gross income includes earned and unearned income
- The applicant should define family size by attesting to how many family members live together
- A pregnant woman's family size includes the child/children in utero
  - For example: if the pregnant woman is married and having twins, for PE purposes, her family size is four

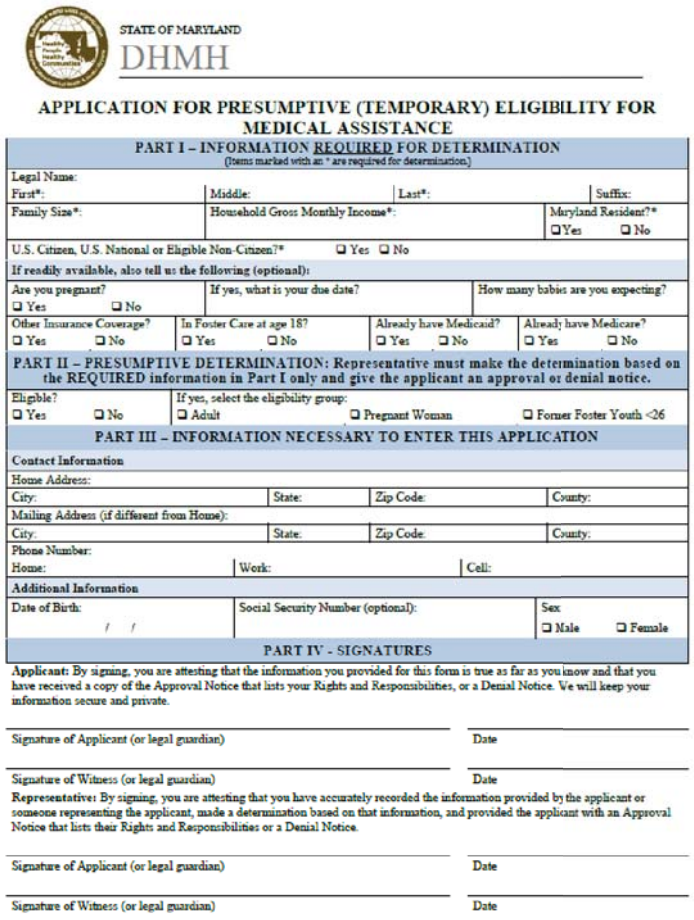
Making PE Determinations: PE Worksheet

Collect the PE applicant's information using the PE worksheet

- The PE worksheet helps to collect basic eligibility information
- The PE worksheet will prompt you on the next step to take
- Use only information provided by the PE applicant or his/her representative
- No additional documentation or verification is required at the time of the PE determination
- Proceed to the PE eMedicaid portal only if you are able to complete the PE worksheet

Making PE Determinations: PE Application

Make sure all required parts of the application are completed for all applicants.



STATE OF MARYLAND
DHMH

APPLICATION FOR PRESUMPTIVE (TEMPORARY) ELIGIBILITY FOR MEDICAL ASSISTANCE

PART I – INFORMATION REQUIRED FOR DETERMINATION
(Items marked with an * are required for determination.)

Legal Name:
First*: | Middle: | Last*: | Suffix:

Family Size*: | Household Gross Monthly Income*: | Maryland Resident?* ❑ Yes ❑ No

U.S. Citizen, U.S. National or Eligible Non-Citizen?* ❑ Yes ❑ No

If readily available, also tell us the following (optional):

Are you pregnant? ❑ Yes ❑ No | If yes, what is your due date? | How many babies are you expecting?

Other Insurance Coverage? ❑ Yes ❑ No | In Foster Care at age 18? ❑ Yes ❑ No | Already have Medicaid? ❑ Yes ❑ No | Already have Medicare? ❑ Yes ❑ No

PART II – PRESUMPTIVE DETERMINATION: Representative must make the determination based on the REQUIRED information in Part I only and give the applicant an approval or denial notice.

Eligible? ❑ Yes ❑ No | If yes, select the eligibility group: ❑ Adult ❑ Pregnant Woman ❑ Former Foster Youth <26

PART III – INFORMATION NECESSARY TO ENTER THIS APPLICATION

Contact Information

Home Address:
City: | State: | Zip Code: | County:

Mailing Address (if different from Home):
City: | State: | Zip Code: | County:

Phone Number:
Home: | Work: | Cell:

Additional Information

Date of Birth: / / | Social Security Number (optional): | Sex ❑ Male ❑ Female

PART IV - SIGNATURES

Applicant: By signing, you are attesting that the information you provided for this form is true as far as you know and that you have received a copy of the Approval Notice that lists your Rights and Responsibilities, or a Denial Notice. We will keep your information secure and private.

Signature of Applicant (or legal guardian) | Date

Signature of Witness (or legal guardian) | Date

Representative: By signing, you are attesting that you have accurately recorded the information provided by the applicant or someone representing the applicant, made a determination based on that information, and provided the applicant with an Approval Notice that lists their Rights and Responsibilities or a Denial Notice.

Signature of Applicant (or legal guardian) | Date

Signature of Witness (or legal guardian) | Date

Notifying the PE Applicant

Notifying the PE Applicant

When are PE determinations made?

- PE determinations are made at the time the application is submitted through the eMedicaid portal.

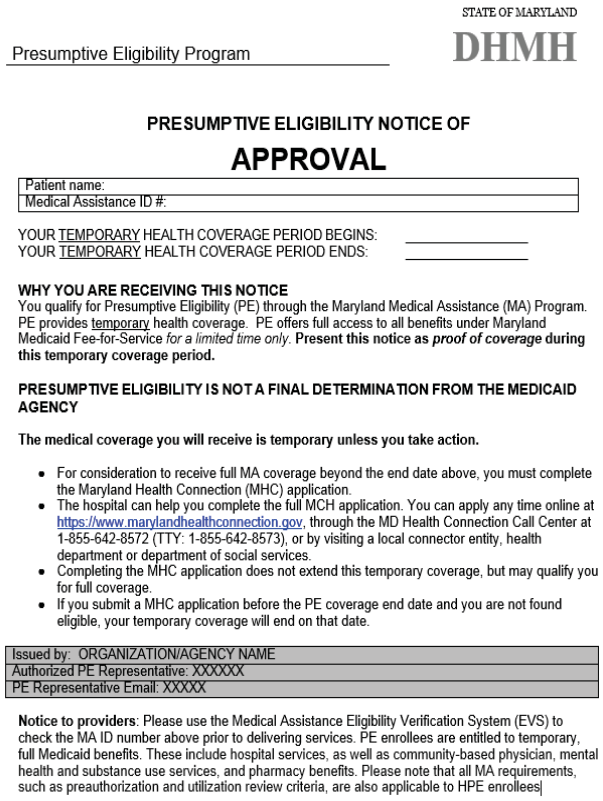
How do you notify applicants of their application status?

- PE workers must provide applicants with written notice on the status of their application, whether eligible or ineligible for coverage.
- The PE eMedicaid portal generates the appropriate notice, which is to be presented to the applicant.

Approved PE Applicants

If an applicant is found eligible for PE coverage:

- eMedicaid generates an Approval Notice. Give this to the applicant.
- The Approval Notice is the PE enrollee's only proof of insurance. They will not receive a Medicaid card.
- Inform PE enrollees if they lose this form, they must return to the facility where they obtained it for another copy.
- A Spanish version is also available.



STATE OF MARYLAND
DHMH

Presumptive Eligibility Program

PRESUMPTIVE ELIGIBILITY NOTICE OF

APPROVAL

Patient name:
Medical Assistance ID #:

YOUR TEMPORARY HEALTH COVERAGE PERIOD BEGINS: _____
YOUR TEMPORARY HEALTH COVERAGE PERIOD ENDS: _____

WHY YOU ARE RECEIVING THIS NOTICE
You qualify for Presumptive Eligibility (PE) through the Maryland Medical Assistance (MA) Program. PE provides temporary health coverage. PE offers full access to all benefits under Maryland Medicaid Fee-for-Service *for a limited time only*. **Present this notice as *proof of coverage* during this temporary coverage period.**

PRESUMPTIVE ELIGIBILITY IS NOT A FINAL DETERMINATION FROM THE MEDICAID AGENCY

The medical coverage you will receive is temporary unless you take action.

- For consideration to receive full MA coverage beyond the end date above, you must complete the Maryland Health Connection (MHC) application.
- The hospital can help you complete the full MCH application. You can apply any time online at https://www.marylandhealthconnection.gov, through the MD Health Connection Call Center at 1-855-642-8572 (TTY: 1-855-642-8573), or by visiting a local connector entity, health department or department of social services.
- Completing the MHC application does not extend this temporary coverage, but may qualify you for full coverage.
- If you submit a MHC application before the PE coverage end date and you are not found eligible, your temporary coverage will end on that date.

Issued by: ORGANIZATION/AGENCY NAME
Authorized PE Representative: XXXXXX
PE Representative Email: XXXXX

Notice to providers: Please use the Medical Assistance Eligibility Verification System (EVS) to check the MA ID number above prior to delivering services. PE enrollees are entitled to temporary, full Medicaid benefits. These include hospital services, as well as community-based physician, mental health and substance use services, and pharmacy benefits. Please note that all MA requirements, such as preauthorization and utilization review criteria, are also applicable to HPE enrollees|

Approved PE Applicants

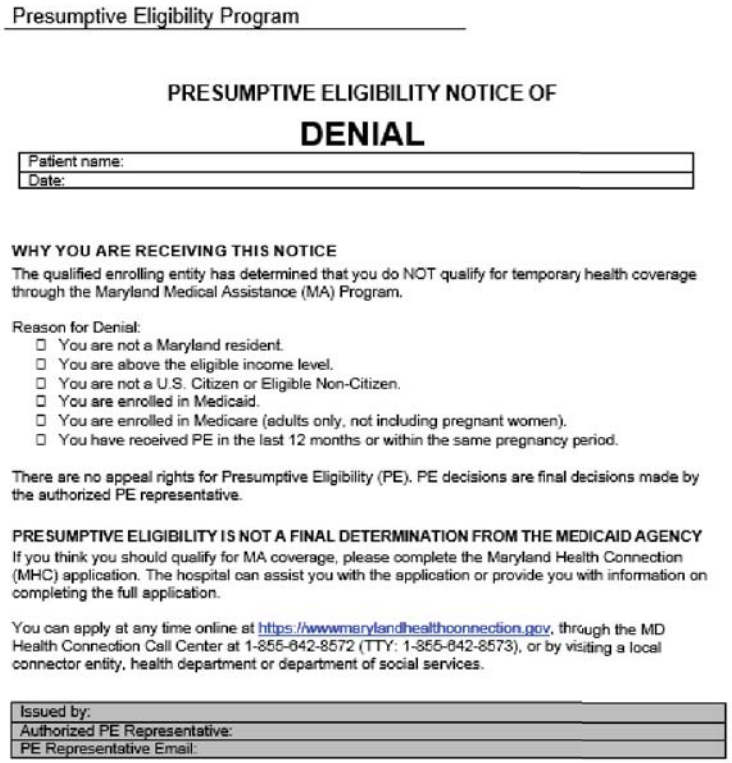
You must also provide the following to all approved PE applicants:

- The full MA application packet;
- An explanation that the individual must complete and submit the full MA application before the temporary PE coverage end date to prevent a coverage gap if they are found eligible for full MA;
- Notice that when the PE coverage period ends, the PE participant will not receive word from the Department; and
- Assistance with completing the full MA application, when possible.

Denied PE Applicants

If the applicant is found ineligible for PE coverage:

- Give the applicant the denial notice. Relay status and reason for denial to applicant.
- Give and/or assist applicant with the full MA application, because they may still qualify.
- Inform applicant that all PE determinations are final, and there are no appeal rights.



Presumptive Eligibility Program

PRESUMPTIVE ELIGIBILITY NOTICE OF

DENIAL

Patient name:
Date:

WHY YOU ARE RECEIVING THIS NOTICE

The qualified enrolling entity has determined that you do NOT qualify for temporary health coverage through the Maryland Medical Assistance (MA) Program.

Reason for Denial:

- ☐ You are not a Maryland resident.
- ☐ You are above the eligible income level.
- ☐ You are not a U.S. Citizen or Eligible Non-Citizen.
- ☐ You are enrolled in Medicaid.
- ☐ You are enrolled in Medicare (adults only, not including pregnant women).
- ☐ You have received PE in the last 12 months or within the same pregnancy period.

There are no appeal rights for Presumptive Eligibility (PE). PE decisions are final decisions made by the authorized PE representative.

PRESUMPTIVE ELIGIBILITY IS NOT A FINAL DETERMINATION FROM THE MEDICAID AGENCY

If you think you should qualify for MA coverage, please complete the Maryland Health Connection (MHC) application. The hospital can assist you with the application or provide you with information on completing the full application.

You can apply at any time online at https://wwwmarylandhealthconnection.gov, through the MD Health Connection Call Center at 1-855-642-8572 (TTY: 1-855-642-8573), or by visiting a local connector entity, health department or department of social services.

Issued by:
Authorized PE Representative:
PE Representative Email:

Denied PE Applicants

Applicants that are determined ineligible must be given a denial notice that indicates the reason for denial.

- Denial reasons includes:
  - Recipient is not a Maryland resident;
  - Recipient is not a US Citizen or Eligible Non-Citizen;
  - Recipient is above the eligible income threshold;
  - Recipient over 65 years old;
  - Recipient indicated or has active Medicaid coverage;
  - Recipient indicated or has active Medicare coverage; or
  - Recipient has prior PE.

Denied PE Applicants

Though a particular PE application may seem eligible at the initial intake stage, eMedicaid will ultimately confirm eligibility

- eMedicaid double checks to ensure the applicant does not have Medicaid, Medicare, or past PE coverage within the last 12 months
- eMedicaid will generate a denial notice and will print the reasons for denial
- For applicants that are found ineligible based on their attestations and not through eMedicaid, PE workers are to check the appropriate box(es) on a paper version of the denial notice and hand it to the applicant.

Enrollment Assistance into Full Medicaid

Enrollment into full Medicaid takes priority over PE.

- PE workers should conduct full MA enrollment first.
- PE determinations are only to be conducted when there are challenges in completing a full MA application.
- PE workers are encouraged to reconnect with applicants soon after PE determinations to assist them with completing the full MA application

The State understands a follow-up full MA application may not always be possible within the facilities due to the ever-changing circumstances for this population.

- Hence, we encourage full applications first.

Enrollment Assistance into Full Medicaid

Full MA application information:

- Applications are online any time at marylandhealthconnection.gov
- Follow the instructions online and input the information as requested
- If retroactive eligibility is necessary, assist the applicant with requesting retroactive coverage for up to three months prior to the month of the full MA application
- If the applicant does not have all the documentation necessary to complete the full MA application, continue filling out the application with all the information the applicant can provide and save the application for a follow up enrollment session

Tracking and Monitoring

The participating PE facility is responsible for maintaining the integrity of the program.

- The PE worker is responsible for keeping accurate records of the PE program at your facility. Every PE worksheet and signed attestation from eMedicaid must be kept in a location that is accessible to all facility PE workers.
- In the event, a PE worker or facility regularly has issues, the Department will require recertification and/or other corrective action measures to address these issues.

Questions

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Individuals above 133% FPL	S50
1902(a)(10)(A)(ii)(XX) 1902(hh) 42 CFR 435.218	
Individuals above 133% FPL - The state elects to cover individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.218. ○ Yes ◉ No	

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Optional Coverage of Parents and Other Caretaker Relatives	S51

42 CFR 435.220
1902(a)(10)(A)(ii)(I)

Optional Coverage of Parents and Other Caretaker Relatives - The state elects to cover individuals qualifying as parents or other caretaker relatives who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.220.

○ Yes ◉ No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Reasonable Classification of Individuals under Age 21

S52

42 CFR 435.222
1902(a)(10)(A)(ii)(I)
1902(a)(10)(A)(ii)(IV)

Reasonable Classification of Individuals under Age 21 - The state elects to cover one or more reasonable classifications of individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.222.

(•) Yes ( ) No

[✓] The state attests that it operates this eligibility group in accordance with the following provisions:

[■] Individuals qualifying under this eligibility group must qualify under a reasonable classification by meeting the following criteria:

[■] Be under age 21, or a lower age, as defined within the reasonable classification.

[■] Have household income at or below the standard established by the state, if the state has an income standard for the reasonable classification.

[■] Not be eligible and enrolled for mandatory coverage under the state plan.

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered at least one reasonable classification under this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013, with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

(•) Yes ( ) No

The state also covered at least one reasonable classification under this group in the Medicaid state plan as of March 23, 2010 with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

( ) Yes (•) No

Reasonable Classifications Previously Covered

The state elects the option to include in this eligibility group reasonable classifications that were covered under the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(•) Yes ( ) No

The state covers all children under a specified age limit, no higher than any age limit and/or income standard covered in the state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013, provided the income standard is higher than the current mandatory income standard for the individual's age. Higher income standards may include the disregard of all income.

( ) Yes (•) No

Medicaid Eligibility

The state covers reasonable classifications of children that were covered under the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013 with an income standard higher than the current mandatory income standard for the age group.

◉ Yes ○ No

The previously covered reasonable classifications to be included are:

Previously Covered Reasonable Classifications Included

Reasonable Classifications of Children S11

☐ Individuals for whom public agencies are assuming full or partial financial responsibility.

☐ Individuals in adoptions subsidized in full or part by a public agency

☐ Individuals in nursing facilities, if nursing facility services are provided under this plan

☐ Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if such services are provided under this plan

☒ Other reasonable classifications

	Name of classification	Description	Age Limit	
+	Pregnant teens	Pregnant teens	Under age 18	X

Enter the income standard used for these classifications (which may be no higher than the highest standard used in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013).

Click here once S11 form above is complete to view the income standards form.

Pregnant teens

☒ Income standard used

☒ Minimum income standard

The minimum income standard for this classification of children must exceed the lowest income standard chosen for children under this age under the Infants and Children under Age 19 eligibility group.

☒ Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

◉ Yes ○ No

The state's maximum standard for this classification of children is no income test (all income is disregarded).

☑ Income standard chosen

Individuals qualify under this classification under the following income standard:

◉ This classification does not use an income test (all income is disregarded).

○ Another income standard higher than the minimum income standard.

New reasonable classifications covered

If the state has not elected to cover the Adult Group (42 CFR 435.119), it may elect to cover additional new age groups or reasonable classifications that have not been covered previously. If the state covers the Adult Group, this additional option is not available, as the standard for the new age groups or classifications is lower than that used for mandatory coverage.

The state does not cover the Adult Group and elects the option to include in this eligibility group additional age groups or reasonable classifications that have not been covered previously in the state plan or under a Medicaid 1115 Demonstration. Any additional age groups or reasonable classifications not previously covered are restricted to the AFDC income standard from July 16, 1996, not converted to a MAGI-equivalent standard.

○ Yes ◉ No

☑ There is no resource test for this eligibility group.

PRA Disclosure Statement

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Children with Non IV-E Adoption Assistance

S53

42 CFR 435.227
1902(a)(10)(A)(ii)(VIII)

Children with Non IV-E Adoption Assistance - The state elects to cover children with special needs for whom there is a non IV-E adoption assistance agreement in effect with a state, who were eligible for Medicaid, or who had income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.227.

(●) Yes ( ) No

[✓] The state attests that it operates this eligibility group in accordance with the following provisions:

[■] Individuals qualifying under this eligibility group must meet the following criteria:

[■] The state adoption agency has determined that they cannot be placed without Medicaid coverage because of special needs for medical or rehabilitative care;

[■] Are under the following age (see the Guidance for restrictions on the selection of an age):

(●) Under age 21
( ) Under age 20
( ) Under age 19
( ) Under age 18

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(●) Yes ( ) No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

(●) Yes ( ) No

[■] Individuals qualify under this eligibility group if they were eligible under the state's approved state plan prior to the execution of the adoption agreement.

The state used an income standard or disregarded all income for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(●) Yes ( ) No

[■] Income standard used for this eligibility group

[■] Minimum income standard

The minimum income standard for this eligibility group is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

[■] Maximum income standard

Medicaid Eligibility

No income test was used (all income was disregarded) for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(•) Yes ( ) No

☒ No income test was used (all income was disregarded) for this eligibility group under (check all that apply):

- ☒ The Medicaid state plan as of March 23, 2010.
- ☒ The Medicaid state plan as of December 31, 2013.
- ☐ A Medicaid 1115 Demonstration as of March 23, 2010.
- ☐ A Medicaid 1115 Demonstration as of December 31, 2013.

The state's maximum standard for this eligibility group is no income test (all income is disregarded).

☒ Income standard chosen

Individuals qualify under this eligibility group under the following income standard, which must be higher than the minimum for this child's age:

This eligibility group does not use an income test (all income is disregarded).

☒ There is no resource test for this eligibility group.

PRA Disclosure Statement

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Optional Targeted Low Income Children S54

1902(a)(10)(A)(ii)(XIV)
42 CFR 435.229 and 435.4
1905(u)(2)(B)

Optional Targeted Low Income Children - The state elects to cover uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.229.

(•) Yes ( ) No

[✓] The state attests that it operates this eligibility group in accordance with the following provisions:

[■] Individuals qualifying under this eligibility group must not be eligible for Medicaid under any mandatory eligibility group.

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group in the state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(•) Yes ( ) No

The state also covered this eligibility group in the state plan as of March 23, 2010.

(•) Yes ( ) No

[■] Until October 1, 2019, states must include at least those individuals covered as of March 23, 2010, but may cover additional individuals. Effective October 1, 2019, states may reduce or eliminate coverage for this group.

[■] Individuals are covered under this eligibility group, as follows:

(•) All children under age 18 or 19 are covered:

(•) Under age 19

( ) Under age 18

( ) The reasonable classification of children covered is:

[■] Income standard used for this classification

[■] Minimum income standard

The income standard for this classification of children must exceed the lowest income standard chosen for children in the age group selected above, under the mandatory Infants and Children under Age 19 eligibility group.

[■] Maximum income standard

Medicaid Eligibility

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for this classification of children to MAGI-equivalent standards and the determination of the maximum income standard to be used for this classification of children under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

◉ The state's effective income level for this classification of children under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for this classification of children under the Medicaid State Plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for this classification of children under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for this classification of children under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ 200% FPL.

○ A percentage of the FPL which may exceed the Medicaid Applicable Income Level, defined in section 2110(b)(4) of the Act, but by no more than 50 percentage points.

■ The state's maximum income standard for this classification of children (which must exceed the minimum for the classification) is:

317 % FPL

■ Income standard chosen, which must exceed the minimum income standard

Individuals qualify under the following income standard:

◉ The maximum income standard.

○ The state's effective income level for this eligibility group under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the effective income level used under the state plan as of March 23, 2010, the state's effective income level for this eligibility group under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ If higher than the effective income level used under the state plan as of March 23, 2010, the state's effective income level for this eligibility group under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the effective income level used under the state plan as of March 23, 2010, the state's effective income level for this eligibility group under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ If higher than the effective income level used under the state plan as of March 23, 2010, 200% FPL.

Medicaid Eligibility

○ If higher than the effective income level used under the state plan as of March 23, 2010, a percentage of the FPL which may exceed the Medicaid Applicable Income Level, defined in section 2110(b)(4) of the Act, but by no more than 50 percentage points.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for this eligibility group in the state plan as of March 23, 2010.

The income standard for this eligibility group is: 317 % FPL

■ There is no resource test for this eligibility group.

■ Presumptive Eligibility

■ Presumptive eligibility for this group depends upon the selection of presumptive eligibility for the Infants and Children under Age 19 eligibility group. If presumptive eligibility is done for that group, it is done for this group under the same provisions.

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Individuals with Tuberculosis	S55
1902(a)(10)(A)(ii)(XII) 1902(z)	
Individuals with Tuberculosis - The state elects to cover individuals infected with tuberculosis who have income at or below a standard established by the state, limited to tuberculosis-related services. ○ Yes ◉ No	

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Independent Foster Care Adolescents S57

42 CFR 435.226
1902(a)(10)(A)(ii)(XVII)

Independent Foster Care Adolescents - The state elects to cover individuals under an age specified by the state, less than age 21, who were in state-sponsored foster care on their 18th birthday and who meet the income standard established by the state and in accordance with the provisions described at 42 CFR 435.226.

◉ Yes ○ No

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ Are under the following age

◉ Under age 21

○ Under age 20

○ Under age 19

■ Were in foster care under the responsibility of a state on their 18th birthday.

■ Are not eligible and enrolled for mandatory coverage under the Medicaid state plan.

■ Have household income at or below a standard established by the state.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 demonstration as of March 23, 2010 or December 31, 2013.

◉ Yes ○ No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

◉ Yes ○ No

■ The state covers children under this eligibility group, as follows (selection may not be more restrictive than the coverage in the Medicaid state plan as of March 23, 2010 until October 1, 2019, nor more liberal than the most liberal coverage in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 demonstration as of March 23, 2010 or December 31, 2013):

◉ All children under the age selected

○ A reasonable classification of children under the age selected:

■ Income standard used for this eligibility group

■ Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

Medicaid Eligibility

☑ Maximum income standard

No income test was used (all income was disregarded) for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

◉ Yes ○ No

☑ No income test was used (all income was disregarded) for this eligibility group under (check all that apply):

- ☐ The Medicaid state plan as of March 23, 2010.
- ☒ The Medicaid state plan as of December 31, 2013.
- ☐ A Medicaid 1115 demonstration as of March 23, 2010.
- ☐ A Medicaid 1115 demonstration as of December 31, 2013.

The state's maximum standard for this eligibility group is no income test (all income is disregarded).

☑ Income standard chosen

Individuals qualify under this eligibility group under the following income standard:

- ○ The minimum standard.
- ◉ This eligibility group does not use an income test (all income is disregarded).
- ○ Another income standard higher than both the minimum income standard and the effective income level for independent foster care adolescents in the Medicaid state plan as of March 23, 2010, converted to a MAGI equivalent.

☑ There is no resource test for this eligibility group.

PRA Disclosure Statement

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Maryland

Method for Determining Cost Effectiveness of Caring for Certain Disabled Children At Home