GUIDE TO
MARYLAND MEDICAL ASSISTANCE
COVERAGE GROUPS

Version April 2022 (Changes in Bold, Italics)

A coverage group is a group of people who meet specific criteria to receive Medical Assistance (also known as Medicaid or MA) or other benefits through Maryland's Medical Care Programs. Recipients in most coverage groups receive care on a fee-for-service (FFS) basis for dental, mental health, and other services. The Affordable Care Act (ACA) provides a new income methodology known as Modified Adjusted Gross Income (MAGI) to determine eligibility for caretakers/parents, children, pregnant women, and adults. We continue to use existing (pre-2014) income and household composition rules for MAGI-exempt eligibility groups, including the Aged, Blind, and Disabled groups and the Medically Needy, and some populations continue to have eligibility determined without reference to income, such as foster children. There are many ways for people to qualify for full Medicaid benefits, for example, by being approved to receive Supplemental Security Income (SSI) or by meeting technical and financial tests for Medical Assistance. There are also limited-benefit Medicaid programs, such as Family Planning, and the Medicare Savings Program that pays Medicare premiums for Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, and Qualifying Individuals (QMB/SLMB***).*** The difference in eligibility rules between coverage groups may be a single criterion. For example, primary caretakers who are younger than 65 years old and have income equal to 123% FPL will be in one group, while primary caretakers younger than 65 with income between 124% and 138% FPL would be in a different group. Consequently, there are many coverage group codes to describe how recipients qualify for benefits.

Although some are obsolete, there are nearly 80 coverage group codes in the Medicaid claims system, MMIS. Each coverage group is identified by a code. The first letter designates the "track," followed by two numbers (e.g., A02). There are a few coverage groups that also have a "type" designation indicated by a letter that follows the two numbers. Some coverage group codes are assigned to recipients by MD THINK, CARES and Maryland Health Connection (MHC) as part of an eligibility determination. Other codes originate with the Maryland Department of Health (MDH), to identify recipients enrolled in programs that are not included in the eligibility systems of record. Generally, users need not know every one of the coverage groups, but should be familiar with the tracks (the alpha designation for coverage groups).

A track is a group of related coverage groups. There are 14 tracks. The same basic eligibility rules are used for all coverage groups in the same track (as in the Aged, Blind and Disabled "S" track), or all groups within the track share a common characteristic (as in the "E" track, which includes all children covered based on placement in foster care or subsidized adoption). Knowing the basic requirements for each track enables the user to quickly understand a recipient's enrollment in a particular coverage group.

The most frequently used tracks were designed based on original federal sub-programs as they existed prior to 2014, for families and children (FAC) (F-track), low income pregnant women and children (PWC) in the P-track, Maryland Children's Health Program (MCHP) for Children's Health Insurance Program (CHIP) groups (P13, P14, D02, D04), and aged, blind, or disabled individuals (ABD) (S-track). Long-term care (MA-LTC) cases have their own tracks, one for ABD individuals (L-track) and another for children (T-track).

The Affordable Care Act (ACA) eliminated references to FAC and PWC, instead referring to individuals who are pregnant women (P-track), children (P-track, plus F98 for children aged 19 to 21), parents or primary caretakers (F05 and new A03), former foster care children aged 19 to 26 (E05), and newly eligible adults (new A02 and A03). The ACA also eliminated the link between Temporary Cash Assistance (TCA) and Medicaid, so that parents and children in the CARES F01 group no longer receive health coverage automatically upon being determined eligible for TCA; instead, they must apply through MHC like other individuals, and their income will be lower than the ACA income limits applied. MCHP children in Maryland's "MA Expansion CHIP" are treated, like other Medicaid children, as members of an individual group rather than a track. The ABD group is unchanged, and MA-LTC is changed only to the extent that T01, corresponding to F01, will not exist: only children will remain in the T-track, and all adults will be handled in the L-track.

Several coverage groups have few, if any, recipients, such as the MA-LTC spend-down group for children (T99). This group is for a child whose monthly income is so high that it exceeds the LTC facility's cost of care, thus placing the child in spend-down. While the circumstances for them rarely occur, such groups are covered under the State Plan and configured in the eligibility system.

Some coverage groups may become obsolete or are not used for new enrollments during a period of time. System edits have been created to prevent new enrollments in the obsolete coverage groups. However, the codes are maintained as implemented—that is, the code is still associated with rules applicable to the original group. Historic descriptions are maintained for use in case of litigation outcomes or settlements that confer eligibility and allow additional provider claims for a time period in the past. Knowing the purpose of an obsolete group is also helpful if an unused code is selected for a new group, to identify programming changes needed for inapplicable rules and edits. That is why a section for Discontinued Groups follows the Active Groups in this Guide.

Coverage Group Definitions

The following is a brief description of each of the coverage groups under the Medicaid Management Information System (MMIS-II). The attached "Quick Reference to Medical Care Program Coverage Groups and HealthChoice Eligibility" may be a more convenient desk reference.

These descriptions do not include all of the eligibility criteria for each group, but are intended to familiarize the user with the coverage groups. This Guide is purely descriptive and does not establish or change policy or procedures, which are specified in official sources. Because of the brevity of these descriptions, they cannot be used as accurate and complete representations of eligibility requirements.

This edition of the Guide presents active groups first, followed by the list of discontinued groups. The tracks are shown alphabetically, and the active groups begin with those subject to Modified Adjusted Gross Income (MAGI) income tests.

CURRENTLY ACTIVE GROUPS

MAGI Adults – A-Track (Effective 1/1/2014)

A02 Adults 19 years old up to 65, (includes disabled income greater than 103% FBR (77% FPL)), maximum income 138% FPL.

Medical Assistance is provided to single adults. Must be at least 19 but not yet 65 years old, and not eligible for Medicare.

A03 Adults 19 years old up to 65 with children under 21 years old, income greater than 123%, maximum income 138% FPL.

Medical Assistance provided to parents and primary caretakers with income from 123%-138% FPL. Must be at least 19 but not yet 65 years old, and not eligible for Medicare.

A04 Disabled adults 19 years old to 65, maximum income 103% FBR (77% FPL), without Medicare.

Disabled adults, not newly eligible, during the 2-year waiting period for Medicare following determination of disability.

Family Planning Presumptive Eligibility (FPPE) - C-Track (Effective March 2021)

C10 Family Planning Clinics can determine presumptive eligibility for consumers of any age or gender.

Effective 3/1/2021, men and women with income at or below 264% FPL are eligible for presumptive eligibility for family planning services. Presumptive eligibility is determined by trained staff at Title X Family Planning Clinics. The covered benefits are the same as for the P10 family planning program.

Hospital Presumptive Eligibility (HPE) – C-Track (Effective 2014)

The ACA allows participating hospitals to determine temporary eligibility for Medical Assistance (MA) for MAGI populations. HPE provides timely access to necessary health care services, immediate temporary medical coverage while full eligibility is being determined, a pathway to community Medicaid coverage, and a coverage determination based on minimal eligibility information.

While eligibility is temporary, individuals eligible for HPE receive full MA benefits during this temporary period. HPE enrollees are not placed in an MCO during the temporary period. Hospitals should file a complete MA application simultaneously whenever possible, especially for pregnant women. HPE period begins with, and includes, the day on which the hospital makes the determination and submits the HPE application via eMedicaid. Hospital Presumptive Eligibility ends the day on which the state makes the eligibility determination for full Medicaid. If the individual fails to submit a full application, Medicaid will end the last day of the month following the month in which the hospital makes the HPE determination

Only one HPE period is allowed every 12 months. Pregnant women are allowed one period of HPE coverage per pregnancy. Presumptive eligibility does not constitute Medical Assistance entitlement determined by the agency, and consequently HPE determinations are not subject to appeal rights.

Hospital Presumptive Eligibility uses simplified income guidelines slightly different from the income standard for corresponding Medicaid groups. The HPE approval notice is the only proof of coverage. The notice displays the HPE coverage end date.

C13M Hospital Presumptive Eligibility: MAGI groups excluding Pregnant Women

C13P Hospital Presumptive Eligibility: Pregnant Women

Correctional Presumptive Eligibility (CPE) (Effective 7/1/2017)

Effective 7/1/2017, Maryland's state Medicaid plan was amended to permit state and local correctional facilities to make presumptive eligibility determinations for pregnant women, former foster care adults and the adult group eligibility groups. Presumptive eligibility does not constitute Medical Assistance entitlement determined by the agency, and consequently CPE determinations, like HPE determinations, are not subject to appeal rights. Prior to release, OES workers assist inmates with completing applications for full-benefit MAGI Medicaid.

C13J Correctional Presumptive Eligibility: MAGI groups excluding Pregnant Women

C13K Correctional Presumptive Eligibility: Pregnant Women

Maryland Children's Health Program (MCHP) Premium – D-Track (Effective 7/1/2001)
Effective 1/1/2014:

- D-track children with MAGI family income certified by Maryland Health Connection (MHC) are transmitted to the MCHP Premium Division at MDH for further processing.
- D-track income standards, converted to MAGI, are 212% to 264% FPL for D02 and 265% to 322% FPL for D04
- D-track children are covered by a fee for service (FFS) span from first day of the month of eligibility until MCO enrollment, like other HealthChoice enrollees.

See COMAR 10.09.43 and the MCHP Premium Eligibility Manual for the policies and procedures for D-track eligibility related to payment of family contribution.

D02 MCHP Premium 212% - 264% FPL

Children younger than 19 years old are enrolled in D02 if their parent or other primary caretaker is willing to pay the monthly premium and if their household income is above 212% and at or below 264% of the FPL. Medical care services for D02 recipients are provided through HealthChoice and FFS for dental, mental health and other services. The premium is equal to 2% of the monthly income of a family of 2 at 200% FPL (the bottom income range before ACA conversion).

D04 MCHP Premium 265% - 322% FPL

Children younger than 19 years old are enrolled in D04 if their parent or other primary caretaker is willing to pay the monthly premium and if their household income is above 265% and at or below 322% of the FPL. Medical care services for D04 recipients are provided through HealthChoice and FFS for dental, mental health and other services. The premium is equal to 2% of the monthly income of a family of 2 at 250% FPL (the bottom income range before ACA conversion).

Foster Care, Subsidized Adoptions & Former Foster Care - E-Track

There are no income or resource tests for these MAGI-exempt groups. These coverage groups provide Medicaid to children who receive foster care, subsidized guardianship, subsidized adoption services through the Social Services Administration of the Department of Human Services (DHS), or are former foster care adults up to age 26. See Medicaid Manual Section 300 for a description of the policies and procedures for eligibility determinations and redeterminations. Note that E01 through E04 are determined on CARES in connection with the associated Social Services programs, while E05 is a new mandatory group determined on MHC.

E01 Title IV-E or SSI, Foster Care or Subsidized Adoption

Medical Assistance is provided to a foster care or subsidized adoption child who receives Supplemental Security Income (SSI) or is determined eligible for assistance under Title IV-E of the Social Security Act.

E02 Non-Title-IV-E, Foster Care or Special Needs Subsidized Adoption & Subsidized Guardianship

Medical Assistance is provided to non-IV-E foster care children who meet the Medical Assistance technical eligibility requirements (e.g., citizenship or eligible alien status, Social Security number). Children eligible for subsidized adoption and subsidized guardianship are also included in this group if they are technically eligible for Medical Assistance and have special needs for medical, mental health, or rehabilitative care. This group also contains independent foster care adolescents not eligible for federal (IV-E) benefits but eligible for state after-care benefits, who can retain MA coverage, without regard to income, until age 21.

E03 State Funded Foster Care

Maryland funds coverage equivalent to Medical Assistance for children in foster care who are not IV-E or SSI eligible and do not meet the Medical Assistance technical eligibility requirements (e.g., citizenship or eligible alien status, Social Security number). Children in this group may not be enrolled in HealthChoice or Rare and Expensive Case Management (REM).

E04 State Funded Subsidized Adoption & Subsidized Guardianship

Maryland funds coverage equivalent to Medical Assistance for children in State subsidized adoption and subsidized guardianship who are not IV-E or SSI eligible and either do not meet the Medical Assistance technical eligibility requirements (e.g., citizenship or eligible alien status, Social Security number) or do not have special needs

for medical, mental health, or rehabilitative care. Children in this group may not be enrolled in HealthChoice or REM.

E05 Former Foster Care up to 26 years old (Mandatory Adult Group Eff. 1/1/2014)

Medical Assistance coverage provided without regard to income for individuals up to age 26 who were in foster care (and concurrent Medicaid) in Maryland on their 18th birthday.

Parents/Primary Caretakers and Children - F-Track

Effective 1/1/2014:

ACA reclassified parents and primary caretakers into coverage groups that no longer match their children's coverage groups. Children are now placed in the P track. The law also delinked Medical Assistance from TCA, so the cash beneficiaries apply for Medical Assistance and fall into parent/caretaker groups based on income. F05 continues for parents and caretakers in the mandatory 1931 group, at 123% FPL (MAGI conversion of 116% FPL), and F98 remains in place for optional children 19 to 21 at 123% FPL.

F02 Post 1931 family MA extension Due to Earned Income (Transitional MA)

Effective 1/1/2019, pursuant to the reinstatement and amendment of §1925 in April 2015, F02 is added to HBX to provide 12 months of Transitional Medical Assistance after the month of closure for former F05 parents and their children, if the parents have had F05 Medical Assistance for at least 3 of the previous 6 months and became ineligible due to increased earnings.

F05 Parents/Primary caretakers [and Children*] up to 123% FPL

Effective 1/1/2014: Medical Assistance is provided to parents or primary caretakers. [*Note: Under ACA, children are to be assigned to age-appropriate P-track groups, but family assistance units have been allowed in F05 for a transitional period. No children should remain in F05 after 12/31/16.]

F98 Children 19 and 20 Years Old, up to 123% FPL

Effective 1/1/2014: Individuals 19 or 20 years old living in their parent's household are eligible in new adult A-track groups.

Effective 7/1/2008: Medical Assistance is provided to children aged 19 and 20 whose income is under 116% FPL, but whose parents are not eligible for F05.

Effective 10/1/1996: Families with dependent children and incomes at or below the medically needy level.

F99 Parents and Children - Medically Needy – Spend-down

Individuals may qualify for federally matched Medical Assistance when they spend down their excess income within the certification period/period under consideration. That is, they become eligible when their incurred medical expenses equal the amount of income that exceeded the income standard. **Spend-down is not available for individuals eligible in the new Adult track.**

Effective 1/1/2014: Due to MAGI conversion, the income "floor" of this group is 123% FPL. Processing for MAGI spend-down is centralized at DHS. Individuals who are overscale for income but have no medical debts can apply for a Qualified Health Plan with a tax subsidy using the common online application. **Individuals eligible under MA spend-down may not be enrolled in HealthChoice.**

Effective 7/1/2008: Families with dependent children, primary caretakers, pregnant women, and children under age 21 who are not eligible for categorically needy groups and whose income exceeds 116% of the FPL qualify for Medical Assistance when they spend down their excess income within the 6-month certification period/period under consideration. That is, they become eligible in a 6-month period after their incurred medical expenses equal the amount of income that exceeded the income standard. **Individuals eligible under MA spend-down may not be enrolled in HealthChoice.**

Effective 10/1/1996: Families with dependent children, primary caretakers, pregnant women and children under age 21 who are not eligible for categorically needy groups, and whose resources are within the MA medically needy standard, qualify for the spend-down process.

Refugees - G-Track

Aliens who are classified as refugees, asylees, or victims of severe trafficking **who are not eligible for Medical Assistance under MAGI or MAGI-exempt rules** may be covered for Refugee Medical Assistance (RMA) services in the G-track. RMA services are authorized under sections of the Immigration and Naturalization Act creating the federal Office of Refugee Resettlement. In Maryland, RMA and related services are administered under an agreement between DHS and the USDHHS Administration for Children and Families, which provides 100% of program costs. Coverage lasts for the first 8 months after either month of U.S. entry as a refugee or effective month of asylum or victim of severe trafficking status. See DHS FIA Manual Release 04-01 with the attached "Refugee Cash Assistance and Refugee Medical Assistance Manual." See also DHS FIA Action Transmittal (AT) 11-31 and AT 02-85, "Increase in Eligibility Standards for RMA" and CARES Bulletin 06-02, "Refugee Medical Assistance."

G01 Refugee Transitional Cash Assistance (RCA)

100% federally funded medical care coverage is provided to adults without dependent children who are determined eligible for Refugee Cash Assistance by a refugee resettlement center. Refugee parents with dependent children are covered under the Temporary Cash Assistance program.

G02 Post RCA Extension Due to Earnings, Hours, Loss of Income Disregards

Federally funded medical care coverage is provided for the first 4 months to persons ineligible for Medical Assistance who lose RCA coverage (G01) due to over-scale income resulting from increased earnings or hours of employment or the loss of earned income disregards.

G98 Refugee Medical Assistance (RMA) - Non-Spend-down

Effective 7/1/2010, the CHIPRA expansion to "lawfully present" pregnant women and children made otherwise eligible refugees and related groups technically **eligible for Medical Assistance and CHIP**. Accordingly, refugees must be confirmed ineligible for Medical Assistance or CHIP in order to be tested for RMA benefit.

Federally funded medical care coverage is provided to refugees, asylees, and victims of severe trafficking who are not receiving RCA and are financially ineligible for federal Medical Assistance as Families and Children, ABD, or MCHP recipients. The income requirements for G98 were changed as of 10/1/2001 from the Medical Assistance medically needy standard to a standard that is less than or equal to 200% of the federal poverty level (FPL). Resources must be within the MA medically needy standard.

G99 Refugee Medical Assistance (RMA) – Spend-down

Federally funded medical care coverage is provided to refugees, asylees, and victims of severe trafficking who are not receiving RCA and are ineligible for Medical Assistance as Families and Children, ABD, or MCHP recipients. Their resources must be within the MA medically needy standard. If their income exceeds the income standard for G98, they qualify for federally matched coverage when they spend-down their excess income within the period under consideration. That is, they become eligible when their incurred medical expenses equal the amount of income that exceeded the income standard. Individuals eligible under spend-down may not be enrolled in HealthChoice.

Home & Community Based Services Waiver Programs and PACE - H-Track

The purpose of a home and community based services waiver program, also known as a "1915(c) waiver," is to enable children or aged, blind, or disabled adults requiring a nursing facility level of care to reside in their homes or community settings rather than in a medical institution.

- Services for waiver participants are federally matched expenses, although these services are not included in the State Medicaid Plan.
- Each waiver program has different medical and other non-financial criteria for its targeted population.
- Income and resources are evaluated for the applicant/recipient as a household of one person, as if the individual were institutionalized and separated from the family unit. Other long-term care rules may be applied for financial eligibility, including spousal impoverishment and look-back for disposal of resources for less than fair market value. If the recipient is placed in an out-of-home community-based facility, the recipient may be assessed a client contribution to pay towards the cost of care.
- Besides being covered for all Medical Assistance State Plan services, waiver participants receive certain services that are only available to individuals enrolled in that particular waiver program. This enables the program to provide appropriate medical and supportive services without institutionalizing the individual.
- Waiver participants, except those in the Model Waiver for Disabled Children, are enrolled in HealthChoice if they are eligible (e.g., not elderly or dually enrolled in Medicare and MA).
- There is a COMAR chapter with policies specific to each waiver program.

Maryland has six home and community-based services (HCBS) waiver programs: Waiver for Children with Autism Spectrum Disorder; Model Waiver for Disabled Children; Home and Community-Based Options Waiver; Waiver for Individuals with Brain Injury; Medical Day Care Services Waiver; and a waiver program for individuals with developmental disabilities, Community Pathways/New Directions. Increased Community Services, an §1115 demonstration program, also functions like an HCBS waiver program. Effective 2014, certain services have been removed from the HSBC waivers and added to a set of state plan long-term services and supports (LTSS) in the Community First Choice program under §1915(k). In addition to the regulations and manuals cited above, information about waiver programs appears in Section 1000 of the online manual.

H01 Home and Community Based Services (HCBS) Waivers and PACE

For persons meeting an HCBS waiver's specific medical and other non-financial criteria, certain financial eligibility rules are waived or changed for the special waiver eligibility group. Income may not exceed 300% of the SSI federal benefit rate, and resources are capped at $2,000.

Effective 11/1/2002, Medical Assistance is provided to individuals at least 50 years old who qualify for the Program of All-Inclusive Care for the Elderly (PACE) as a State Plan option. The same Medical Assistance eligibility rules are used for PACE as for HCBS waivers. The PACE provider receives monthly capitation from both Medicare and Medical Assistance for all medical and supportive services received either in the home and community or in medical institutions (including long-term care facilities).

H02 HCBS Waiver Participants Processed on E&E

Effective with the March 2021 start of the rollout of E&E, this group has been added for community-eligible individuals who are participants in the HCBS waiver programs. For MAGI participants, the community coverage groups are parents/caretaker relatives (F05), dependent children aged 19 and 20 (F98), children (P07), and former foster care children (E05). The non-MAGI community coverage groups are Public Assistance for Adults recipients (S01), SSI recipients (S02), medically needy without spend-down (S98), federal foster care and subsidized adoption (E01 and E02), and Employed Individuals with Disabilities (S13D). On CARES, community-eligible recipients typically retained their original coverage group codes.

H98 Waiver Participants Losing SSI

Effective with the March 2021 start of the rollout of E&E, this group, formerly for ABD medically needy participants (S98), was revived and repurposed for individuals who originally qualified for HCBS waiver programs as S02 but subsequently lost eligibility for SSI (while continuing to be medically eligible for the waiver program).

Aged, Blind or Disabled (ABD) Long-term Care (LTC) – L-Track

L01 SSI-Only Recipient in Long-term Care

Medical Assistance is provided to cover the cost of care in long-term care facilities for adults and children whose sole income source is Supplemental Security Income (SSI) (coverage group S02 in the community). Their other medical services are also covered. Institutionalized SSI recipients are made eligible for L01 if they have no income besides

their SSI benefit. If they have other income to contribute towards their cost of care, the children are determined eligible in coverage group T02 and the adults in L98.

L98 ABD Long-term Care

Medical Assistance is provided to cover a portion of the cost of care in long-term care facilities, for aged, blind or disabled persons whose available income is insufficient to meet the entire cost in the long-term care facility. The resource limit is $2,500. Other medical services are also covered.

L99 ABD Long-term Care – Spend-down

Medical Assistance is provided to aged, blind or disabled persons if their available income exceeds the cost of care in a long-term care facility, but they have other incurred medical expenses that exceed their excess available income. The resource limit is $2,500. Medical Assistance does not cover cost of care in the long-term care facility, but does cover other medical services that are not used for spend-down.

Pregnant Women and Children – P-Track

Update 4/1/2022- Pregnant and postpartum women in P02 and P11 coverage groups, unlike most Medicaid participants, do not have a 12-month certification period. Instead, they are covered during pregnancy and a postpartum periods. Effective 4/1/2022 through 4/1/2027, the American Rescue Plan Act (ARPA) has been authorized, and Maryland has adopted an extended postpartum period of 12 months after the month in which pregnancy ends. The postpartum period also applies to pregnant women in other Medicaid coverage groups. Historically in the original Medicaid statute, the postpartum period was 60 days beginning at the end of pregnancy; coverage ended at the end of the month in which the 60th day occurred. Pregnant and postpartum women are subject to continuous eligibility during the pregnancy and postpartum period. Under original rules, this meant that an increase in income would not cause a pregnant or postpartum woman to lose coverage. Under the ARPA, pregnant and postpartum women also retain coverage regardless of changes in household composition, aging out of a coverage group, or loss of SSI.

Unless Congress extends the authorization, the 12-month postpartum period will no longer be available to women reporting pregnancy or applying for P02/P11 coverage after March 31, 2027.

Effective 1/1/2014

Pregnant women are counted as 1 plus the number of children expected. Family members of a pregnant woman who are applying separately can count both pregnant woman and expected children in their household size.

The P-track covers eligible children under 19 years old and pregnant and postpartum women. Coverage groups P01 through P12 are Medicaid groups; coverage groups P13 and P14 are in MCHP (CHIP), along with the D-track MCHP Premium coverage groups. There is no resource test for these groups. See COMAR 10.09.24 and the LHD Eligibility Manual for the policies and procedures for determining eligibility for pregnant women and Medicaid children.

P02 Pregnant Women Up to 189% of the Federal Poverty Level (FPL)

Medical Assistance coverage is provided to pregnant women whose household income is at or below 189% of the FPL. This coverage continues for the postpartum period, until the end of the 2nd month following the end of the pregnancy. ***Effective 4/1/2022, the postpartum period continues through the end of the 12th month following the end of the pregnancy.***

P06 Children Under 1 Year

Under ACA, the P06 coverage group now covers newborns of P02 and P11 mothers as well as other children under the age of 1.

Medical Assistance coverage is provided to children under 1 year old if the child's mother was covered by Medical Assistance for the child's date of birth (including a mother covered retroactively or as an alien in the X-track). When the newborn is added to the mother's Medical Assistance case in the Maryland Health Connection, the newborn receives coverage for a full year regardless of changes in the family income. This group also includes newborns who are certified by MDH based on documentation of birth received directly from the hospital or managed care organization (1184 process).

Medical Assistance coverage is provided by application to children who are under 1 year old and whose household income is at or below 199% of the FPL.

P07 Children Age 1 Up to 19 Years Old

Children 1 up to 6 Years Old, up to 143% of the FPL
Medical Assistance coverage is provided to children who are at least 1 year old but less than 6 years old, if household income is at or below 143% of the FPL.

Children 6 up to 19 Years Old, up to 138% of the FPL
Medical Assistance coverage is provided to children up to their 19th birthday, if their household income is at or below 138% of the FPL.

P11 Pregnant Women, 190% - 264% of the FPL

Medical Assistance coverage is provided to pregnant women whose household income is above 190% and at or below 264% of the FPL. Except for the higher income level, the eligibility and coverage for this group is identical to P02. This coverage continues for the postpartum period, until the end of the 2nd month following the end of the pregnancy. ***Effective 4/1/2022, the postpartum period continues through the end of the 12th month following the end of the pregnancy.***

P13 MCHP (Title XXI) – Children Age 1 up to 19 Years Old, up to 189% of the FPL

The Maryland Children's Health Program (MCHP) provides medical coverage to uninsured children up to their 19th birthday. They do not qualify as P07 because their household income exceeds the limit for those coverage groups. Their household income is at or below 189% of the FPL.

P14 MCHP (Title XXI) – Children Under 19 Years Old, 190%-211% of the FPL

The Maryland Children's Health Program (MCHP) provides medical coverage to uninsured children under the age of 19 whose household income is above 190% and at or below 211% of the FPL. Children are certified in this coverage group only if they fail to qualify for coverage as P13 due to household income that exceeds 189% of the FPL.

Family Planning/Reproductive Health Limited Benefit

P10 Medicaid Family Planning Program (MFPP)

Effective 7/1/2018, men and women with income at or below 264% FPL are eligible for family planning services in this limited-benefit group. This benefit program provides age- and sex-specific services related to birth control and reproductive health, but does not cover abortion services. Individuals can submit an application to determine eligibility for coverage of MFPP services. Also effective 7/1/2018, pregnant women eligible for coverage groups P02 and P11 are automatically covered for **family planning services** for one year when their P02 or P11 eligibility ends after the postpartum period. The P10 group is found on MMIS but effective 8/2019 will transition to Maryland Health Connection eligibility system (see group types below).

P10 N Family Planning limited benefit for postpartum women
P10 U Family Planning via Healthy Maryland application—no new applicants after 8/2019
P10 M Family Planning via MHC application effective 8/2019

This family planning group continues to cover women following postpartum period in P02, and resumes covering women following P11 (terminated in 2012 with FPL change to 200%), but is now **open to both sexes** by application for limited benefit, so has been moved to a new section immediately above W01 and X-Track sections.

Aged, Blind, or Disabled (ABD), Medicare Savings Program, S-Track

S01 Public Assistance to Adults - PAA

Federally matched Medical Assistance is provided to persons who are recipients of Public Assistance to Adults (PAA), a State-funded program administered by DHS. PAA provides grants to support ABD adults in out-of-home, community-based residences (Project HOME adult foster care, certain assisted living facilities, and Mental Hygiene Administration residential rehabilitation programs). Included in this coverage group are persons who do not receive a PAA benefit because of recoupment, because the grant is less than $10, or because the case is suspended. See DHS's COMAR 07.03.07 for the eligibility policies and procedures specific to PAA.

S02 Supplemental Security Income (SSI) Recipients

Federally matched Medical Assistance is provided, without a separate MA application and without an annual MA redetermination, to all SSI recipients (children and adults) for as long as the U.S. Social Security Administration categorizes them as SSI recipients. This group includes persons who do not receive an SSI check but whom the Social Security Administration still deems SSI eligible, such as Disabled Adult Children (DACs) (see Policy Alert 03-3), Disabled Widowed Beneficiaries (DWBs) (see Policy

Alert 03-4), and certain non-elderly disabled or blind individuals who lose SSI benefits due to employment. For the federal SSI eligibility policies and procedures, see Title 20 of the U.S. Code of Federal Regulations (CFR). DACs receive notice of their status from Social Security, while DWBs must apply to SSA. The DWB benefit ends at age 65.

S03 Qualified Medicare Beneficiaries (QMB)

Persons who are eligible for Medicare receive federally matched Medical Assistance coverage of their Medicare Part B (Medical Insurance) premiums, as well as coverage of their co-payments and deductibles for services covered under Medicare Part B (up to the maximum Medicaid rate for the service). Medicare Part A (Hospital Insurance) premiums are also covered if the individual is not entitled to free coverage due to insufficient qualifying working quarters. For QMB eligibility, income of the applicant (or applicant and spouse) must be at or below 100% of the federal poverty level, and resources may not exceed three times the SSI standard, subject to annual adjustment. QMB resources are also subject to a $1500 burial allowance and a disregard for the value of life insurance policies.

S04 Pickle Amendment

Medical Assistance is provided to persons who meet the criteria specified in the federal law known as the "Pickle Amendment." These are persons who would be eligible for SSI except that their Social Security benefits increased as the result of an annual cost of living adjustment and caused them to exceed the income standard for SSI eligibility. See DHS FIA AT 00-12.

S05 Disabled Widowed Beneficiaries (DWB) §1634(d)

Persons eligible in this coverage group lost SSI eligibility because a change in the federal disability definition enabled them to qualify for Social Security benefits. Federally matched Medical Assistance is provided to these persons if they would be eligible for SSI except for the fact that the Social Security cash benefit causes them to exceed the SSI income standard.

S06 Qualified Disabled and Working Individuals (QDWI)

Non-elderly persons who are entitled to Medicare Part A (Hospital Insurance) by reason of their disability, but who are not eligible to receive a Social Security benefit because they are employed, may be eligible for federally matched Medical Assistance coverage of their **Medicare Part A premiums** if their income is at or below 200% of the federal poverty level and their resources do not exceed twice the SSI standard. A card is not issued for QDWI recipients since the benefit does not cover any medical services.

S07 Specified Low Income Medicare Beneficiaries (SLMB)

Medicare recipients are eligible for SLMB if they have income above 100% of the FPL (the QMB income limit) but less than 120% of the FPL. The SLMB resource standard is the same as for QMB--three times the SSI standard, as adjusted annually for inflation. Their resources are also subject to a $1500 burial allowance and a disregard for life insurance policies. These individuals are eligible for federally matched Medical

Assistance coverage of only their **Medicare Part B premiums**. A card is not issued for SLMB recipients, since the benefit does not cover any medical services.

S13-D Employed Individuals with Disabilities Program (EID)

Effective 10/1/2008, the Employed Individuals with Disabilities Program (EID) was expanded to permit individuals with disabilities throughout the state to be eligible for Medical Assistance coverage and remain in the workplace. The EID program began on 4/1/2006 as a waiver program that provided buy-in to Medical Assistance for a limited number of individuals with disabilities who would otherwise not qualify due to earnings.

A separate application is required for the EID Program. EID certifications are made by the MDH Eligibility Determination Division (EDD). This coverage group is on MMIS, not on CARES. Beneficiaries are covered on a fee-for service basis for full Medical Assistance benefits, with the exception of services in long-term care facilities, Rare and Expensive Case Management, the PACE program and certain home and community-based waivers. Individuals must pay a monthly premium to participate in EID. Individuals qualify for EID if they are at least 18 but not yet 65 years old, are employed or self-employed, have been determined disabled by the Social Security Administration, receive Social Security Disability Insurance (SSDI) or lost SSI or SSDI solely due to employment, have income no more than 300% of the FPL, and have resources no more than $10,000 for single persons and $15,000 for a couple. For individuals who have a 401(k), 403(b), pension plan or Keogh plan, the individual's ownership interest is excluded from the aggregate current cash value when determining the resource amount.

The "D" coverage type distinguishes EID recipients from recipients formerly placed in the S13 group for accelerated certification of a case used in a special study.

S14 Qualifying Individuals (Qualifying Individual 1—QI-1)

Individuals whose income is at least 120% but less than 135% of the federal poverty level, and whose resources do not exceed three times the SSI standard as adjusted for inflation, disregarding $1500 as a burial allowance and cash value of any life insurance, qualify for Medical Assistance coverage limited to their **Medicare Part B premiums**. **A card is not issued** for these recipients since the benefit does not cover any medical service. This group is distinguished from SLMB only by a higher income standard and an enhanced federal match for state expenditures.

S16 Increased Community Services Program (ICS)

Beginning 1/1/2012, Maryland opened a demonstration program to provide Medicaid-covered services in home and community-based settings rather than in nursing facilities for individuals eligible for MA-LTC, who would be ineligible due to excess income when tested under community rules. This demonstration is, like Maryland's HCBS waiver programs, subject to a cap on the number of participants. Resources are capped at $2,500.

S19 Disabled Adult Children (DAC) §1634(c) (Added effective 11/15/2020)

Beginning November 16, 2020, Maryland added a coverage group code for Disabled Adult Children who became eligible for SSDI based on OBRA 1990 but who SSA continues to deem eligible for SSI for purposes of eligibility for Medical Assistance. These individuals were formerly included in S02 coverage code.

S20 Disabled Widowed Beneficiaries (DWB) §1634(b) (Added effective 11/15/2020)

Beginning November 16, 2020, Maryland added a coverage group code for Disabled Widowed Beneficiaries who became eligible for SSDI based on OBRA 1990 but who SSA continues to deem eligible for SSI for purposes of eligibility for Medical Assistance. These individuals were formerly included in S02 coverage code.

S21 Temporary Category for Children Losing SSI Transitioning to Other Children's Medicaid Coverage Groups (Added effective 11/15/2020)

Children with SSI are automatically covered in S02, but if they are no longer disabled, MDH uses this coverage group to hold them while case managers reach out to obtain their family's income information in order to transition them in the correct children's coverage group. For MAGI, this would be a coverage group in the Maryland Health Connection. For Foster Care and Adopted children, a coverage group in the E-track CARES, and for Long-term Care children, a coverage group in the T-track Eligibility & Enrollment.

S98 ABD Medically Needy – Non-Spend-down

Medical Assistance is provided to aged, blind, or disabled persons whose income and resources (including those of their spouse living with them) are within the MA community medically needy income and resource standards.

S99 ABD Medically Needy – Spend-down

Aged, blind, or disabled persons, whose resources are within the MA community medically needy resource standard but whose income exceeds the medically needy income standard, qualify for Medical Assistance within the period under consideration when they spend-down their excess income. That is, they become eligible when their incurred medical expenses equal the amount of income that exceeded the income standard. Individuals eligible under MA spend-down may not be enrolled in HealthChoice.

<u>Children's Long-term Care - T-Track</u>

See Section 300 of the online manual for a description of policies and procedures for eligibility determinations and redeterminations for these long-term care coverage groups.

T02 P-track and Other Children in Long-term Care

Medical Assistance is provided for a child under 21 years old (as a household of one) who resides in a LTCF, if the child meets the medically needy resource standard and the child's income (other than SSI) is insufficient to pay the LTCF's cost of care. For a child eligible under community standards, the taxpayer or non-filer household rules will be

used to calculate family income for the child. Medical Assistance will pay the portion of the cost of care in the facility that exceeds the child's available income, and will cover their other medical services.

T03 Children Under 1 Year Old in Long-term Care (P06 Standards)

Medical Assistance is provided for a child under 1 year old with income **at or below 199% of the FPL** who resides in a LTCF. The child is considered as a household of one person, and must pay his or her available income towards the cost of care in the LTCF. Otherwise, eligibility rules for P06 are used. **There is no resource test.**

T04 Children Age 1 Year Old Up to 6 Years Old in Long-term Care

Medical Assistance is provided for a child who is at least 1 year old but less than 6 years old with income **at or below 143% of the FPL** who resides in a LTCF. The child is considered as a household of one person, and must pay his or her available income towards the cost of care in the LTCF. Otherwise, usual eligibility rules for children are used. **There is no resource test.**

T05 Children Age 6 up to 19 Years Old in Long-term Care

Medical Assistance is provided for a child age 6 up to 19 years old with income **at or below 138% of the FPL** who resides in a LTCF. The child is considered as a household of one person, and must pay his or her available income towards the cost of care in the LTCF. **There is no resource test.**

T99 Children in Long-term Care – Spend-down

Children under 21 years old who reside in a LTCF, whose resources do not exceed the medically needy resource standard for a household of one person, but whose available income exceeds the cost of care in the LTCF, are eligible for Medical Assistance if they have other incurred medical expenses that exceed the excess available income. Medical Assistance does not pay towards the cost of care in the LTCF but does cover the child's other medical services.

Women's Breast or Cervical Cancer - W-Track
(No new applications accepted after 12/31/2013)

W01 Women's Breast and Cervical Cancer Health Program (WBCCHP)

Medical Assistance is provided to women aged 40 up to 65 who are diagnosed with breast or cervical cancer, need treatment, and are uninsured (or whose insurance does not cover cancer treatment). Eligible women were required to be screened through the Maryland Breast and Cervical Cancer Screening Program. The Screening program is funded by the Centers for Disease Control and administered by the local health departments or other contracted entities. Since MDH determines eligibility, this coverage group is found on MMIS, not on CARES or MHC.

Aliens - X-Track

X02 Non-MAGI Undocumented or Ineligible Aliens – Emergency Medical Services

Medical Assistance coverage for **emergency medical services** is provided to undocumented or ineligible immigrants who are technically (including Maryland residency) and financially eligible for ABD with or without spend-down (S98 or S99), except that they do not meet the citizenship or alien eligibility requirements. A card is not issued because this coverage is limited to payment for emergency medical services that have generally already been received. Eligibility is determined based on a professional review of medical records by a Utilization Control Agent (contractor) to evaluate if the services received meet the criteria for emergency services.

X03 MAGI Undocumented or Ineligible Aliens – Emergency Medical Services (began November 1, 2020)

Medical Assistance coverage for emergency medical services is provided to undocumented or ineligible immigrants who are technically (including Maryland residency) and financially eligible for MAGI (Coverage Groups in Tracks A, D, F and P), except that they do not meet the citizenship or alien eligibility requirements. A card is not issued because this coverage is limited to payment for emergency medical services that have generally already been received. Eligibility is determined based on a professional review of medical records to evaluate if the services received meet the criteria for emergency services. Federally matched coverage for labor and delivery is also extended to undocumented or unqualified women under this emergency service provision. Pregnant women who are undocumented or unqualified are permitted to enroll early in their pregnancy as a convenience to hospitals, but payments made on their behalf are restricted to services with labor and delivery procedure codes.

H13 Walter Lomax- Healthcare to Individual Erroneously Convicted (began July 1, 2021)

The Compensation to Individual Erroneously Convicted, Sentenced, and Confined (The Walter Lomax Act) (SB014/HB742, Chs. 76 and 77 of the Acts of 2021), requires the Maryland Department of Health to provide healthcare coverage, including dental services, for at least five years for any individual erroneously convicted, sentenced, and confined under State law for a crime the individual did not commit. The law took effect on July 1, 2021.

DISCONTINUED GROUPS

MAGI Adults

A01 Childless Adults 19 up to 65, maximum income 138% FPL (Former PAC Enrollees)

Childless adults formerly covered under the PAC program were placed in A01 group effective 1/1/2014 to assist in tracking this portion of the newly eligible adult track. Effective 10/1/2016, all were moved to the common A02 track (or to S-track groups if no longer eligible for MAGI).

MCHP

D01 Discontinued 7/1/2003: Employer-Sponsored Insurance (ESI) 200% - 250% FPL

Medical services for D01 recipients were provided through employer-sponsored insurance (ESI) with premium payment from Medicaid. This enrollment option was discontinued effective 7/1/2003, and existing enrollees were enrolled in HealthChoice at the end of their ESI benefit year.

D03 Discontinued 7/1/2003: Employer-Sponsored Insurance (ESI) 250% - 300% FPL

This group differed from D01 in having a higher income standard and imposing a higher contribution (premium) amount.

D02 and **D04** History

Effective 7/1/2004:

- D02 and D04 MCHP Premium coverage groups opened to new enrollments after being frozen for 7/1/2003 – 6/30/2004.
- The P14 coverage group transferred back to free MCHP after being in MCHP Premium from 9/1/2003 – 6/30/2004.

- **Effective 1/1/2007:** D02 and D04 MCHP Premium coverage groups were added to Maryland's Medicaid Expansion CHIP program (P13 and P14), leaving Maryland with no stand-alone CHIP coverage.

Effective 7/1/2003:

- The MCHP Premium program continued to cover uninsured children under the age of 19 with family income above 200% of the federal poverty level (FPL) and at or below 300% of the FPL who had been determined eligible for D02 or D04 prior to 7/1/2003. The program was closed to new enrollment for the fiscal year ending 6/30/2004.
- The Medicaid Premium Division at MDH tested children for a D-track MCHP Premium coverage group after CARES certified them as having family income greater than 200% and less than or equal to 300% FPL. MCHP Premium coverage requires that the family pay a monthly contribution (not a per-child premium). Eligibility did not begin until the family made the first premium payment and selected an MCO. As eligibility for MCHP Premium was determined at MDH, the coverage groups were found only on MMIS, not on CARES.
- Recipients in D02 and D04 receive their medical care only through HealthChoice, Maryland's Managed Care Program. At this time, these recipients differed from other HealthChoice enrollees because they did not receive fee for service (FFS) benefits prior to their enrollment with a managed care organization (MCO).

F01 Temporary Cash Assistance (TCA) Recipients - Section 1931
Discontinued for Medical Assistance 1/1/2014

Effective 1/1/2014, TCA recipients apply separately for Medicaid and are assigned to parent/caretaker, pregnant woman, child, or adult groups

(Effective 10/1/1996)
Federally matched Medical Assistance is automatically provided to children and families approved for TCA, even if their cash benefit amount is $0. Effective October 1, 1996, federal welfare reform abolished the Aid to Families with Dependent Children (AFDC) program and replaced it with Temporary Assistance for Needy Families (TANF). Section 1931 of the Social Security Act permits states to adopt Medical Assistance (MA) rules that are more liberal than the 1996 AFDC rules. Maryland adopted more liberal MA rules in order to match the rules for TCA, Maryland's TANF program. See DHS's TCA Manual and COMAR 07.03.03 for the policies and procedures for determining TCA eligibility.

F02 Post TCA MA Extension Due to Earned Income (Transitional MA)

Effective 1/1/2014
Medical Assistance is provided to former F01 parents and children who were receiving Medical Assistance for at least 3 of the previous 6 months and lose Medical Assistance eligibility due to income from new employment or increased hours of employment. Maryland elected the 12-month certification period, Social Security Act §1925(a)(5). Effective 1/1/2010, families receive Transitional Medical Assistance for 12 months from the month of closure. Effective 2015, Public Law 114-10 authorized Transitional MA permanently, so it ceased to be subject to annual renewal, and replaced the 4-month extension at 1902(e)(1) with a reference to the Transitional Medical Assistance section.

See F02 in Current Groups effective 1/1/2019 for post-1931 TMA

F03 Post TCA MA Extension Due to Child or Spousal Support (Transitional MA)

Discontinued 1/1/2019
Due to changes in IRS rules excluding spousal support from taxable income, and the non-taxable status of child support income, the F03 group will not be implemented in MHC).

Discontinued 1/1/2014
Transitional Medical Assistance is provided to F01/F05 recipients who were receiving Medical Assistance for at least 3 of the previous 6 months and lost Medical Assistance eligibility due to over-scale income from increased collections of child or spousal support. Effective 1/1/2010, eligibility in this group is limited to 12 months from the month of the closure.

Effective 10/1/1996
Extended Medical Assistance was furnished to F01 families who ceased to receive Medical Assistance when increased income due to new employment or increased hours of employment made them ineligible for TCA, and who had received Medical Assistance for at least 3 of the previous 6 months. From 10/1/1996 through 12/31/2009, beneficiaries received 4-month Medicaid Extension; effective 1/1/2010, beneficiaries receive 12 months of Transitional Medical Assistance.

F04 Discontinued 7/1/2008: TCA Closed/Denied Due to Non-MA Requirement - § 1931

Medical Assistance was provided to persons who lost or were denied eligibility under F01 and TCA because they failed a non-financial TCA requirement that was not a requirement of Maryland's Medical Assistance (e.g., failed to meet a TCA work requirement), but who were otherwise qualified for TCA.

Effective 7/1/2008: Medical Assistance for the F05 group covers parents or primary caretakers with dependent children under age 21 whose income is at or below 116% FPL. Children in P-track coverage with income at or below 116% were combined in an assistance unit with their F05 parents.
Effective 11/1/1991: The F-track is for eligible families with dependent children and for other eligible children under the age of 21. Families consist of parent(s) (biological, step or adoptive) or other primary caretakers and unmarried children living with them.

Home and Community Based Services

H98 Discontinued: Home and Community Based Services (HCBS) Waiver - Medically Needy – Non-Spend-down

For persons who met the medical and other non-financial criteria for the Older Adults Waiver (now known as Home and Community-Based Options Waiver) but who failed the resources test, eligibility was established by meeting the MA community medically needy resource and income standards. Financial eligibility was determined as if the person were living separately from the family unit. There is **no spenddown for income**.

Note: This code has been revived and repurposed for HCBS waiver participants processed in E&E as H02 based on SSI eligibility who subsequently lose eligibility for SSI. See entry at H02 in current groups above.

H99 Not in Use (Coverage group never used): Home and Community Based Services (HCBS) Waiver

Pregnant Women and Children

P01 Discontinued 7/1/1997: General Public Assistance to Pregnant Women
Pregnant women who were ineligible for AFDC because they were not in their last trimester, and who were eligible for GPA-PW (State-only cash assistance), were granted federally matched Medical Assistance. This coverage group was discontinued 7/1/1997

due to federal welfare reform (the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, known as "PRWORA").

P03 Newborns of P02 Mothers

Effective 1/1/2014: consolidated under P06
Medical Assistance coverage is provided to children under 1 year old if the child's mother was covered by Medical Assistance for the child's date of birth (including a mother covered retroactively or as an X02 alien). Since these newborns are deemed eligible based on the mother's eligibility, an application is not necessary. This group also includes children who are certified by MDH based on documentation of birth received directly from the hospital or managed care organization (1184 process). This group did not include newborns of P11 mothers (see P11 and P12).

P04 Discontinued 7/1/1998: Medically Needy Newborns

Medical Assistance coverage was provided to children under one year old if the child's mother was receiving Medical Assistance as a medically needy person at the time of the child's birth. Effective 7/1/1998, CARES and MMIS ceased to accept certifications in this group, as these newborns were then added to the P03 coverage group.

P05 Discontinued 7/1/1997: Newborns of Women Who Would be Eligible if Pregnant

Medical Assistance was provided to children under 12 months old who reside with their mothers, if their mothers were receiving Medical Assistance at the time of birth and would still be receiving Medical Assistance if they were pregnant. Effective 7/1/1998, CARES and MMIS ceased to accept current certifications in this group, as these newborns were then added to the P03 coverage group.

P08 Children Age 6 up to 19 Years Old, up to 138% of the FPL

Effective 1/1/2014: consolidated under P07
This code is no longer used. New P07 includes two distinct subsets: children ages 1 up to 6 with 143% FPL, and children ages 6 up to 19 with 138% FPL income standard.

P09 Discontinued 7/1/1998: Maryland Kids Count Waiver

Children born after 9/30/1983 whose family income exceeded the standards for full-benefit Medical Assistance under Pregnant Women and Children (PWC) received limited coverage for outpatient services in this coverage group. Effective 7/1/1998, children with family incomes up to 200% of FPL are eligible for full benefits in the CHIP coverage groups P13 and P14.

P12 Newborns of P11 Mothers

Effective 1/1/2014: consolidated under P06
Medical Assistance coverage is provided to children under 1 year old, if the child's mother was covered as a P11 for the child's date of birth, including retroactively. This

group also included children who are certified by MDH based on documentation of birth received directly from the hospital or MCO (1184 process).

Aged, Blind and Disabled

S08 Discontinued 6/1/2006: SLMB and Maryland Pharmacy Assistance Program (SLMB/MPAP)

Persons who were eligible for both SLMB (see S07) and the Maryland Pharmacy Assistance Program (see S09 history) were assigned a single coverage group code on MMIS. S08 was generated by MMIS, while these recipients continued to appear as S07 on CARES. With the implementation of Medicare Part D between 1/1/2006 and 5/15/2006 for pharmacy coverage of Medicare beneficiaries, SLMB recipients in coverage group S08 were moved to S07 on MMIS when their enrollment in a Medicare prescription drug plan was confirmed by MDH.

S09 Discontinued 12/31/2013: Primary Adult Care Program (PAC)
Effective 1/1/2014 members moved to full-benefit A01 coverage—see A-track above

Primary Adult Care Program (PAC): Beginning 7/1/2006, the Maryland Pharmacy Assistance Program was combined with the Maryland Primary Care Program to create the Primary Adult Care Program. The program covered primary care, outpatient specialty mental health services and pharmacy benefits furnished through PAC Managed Care Organizations (separate from HealthChoice MCOs) and authorized under a Medicaid demonstration waiver ("§1115 waiver"). Effective 1/1/2010, substance abuse services and the facility costs of Emergency Room visits were added to PAC benefits. To be eligible, an individual or couple had to be at least 19 years old, not eligible for Medicare, not institutionalized, and not claimed as a dependent by a parent for income tax purposes. As of 4/1/2009, to be eligible for services under the PAC program, income could not exceed 116% of the federal poverty level (FPL) for a household of one person or a couple; and there was no resource test. PAC certifications were made at MDH using an independent eligibility system, so PAC recipients were on MMIS but **not** on CARES.

S09 Discontinued 6/30/2006: Maryland Pharmacy Assistance Program (MPAP).

Beginning 10/1/2002, persons who were ineligible for MA and MCHP could apply for coverage of **prescription medications through MPAP**. Effective 1/1/2006, Medicare beneficiaries could no longer participate in the Medicaid-funded MPAP because pharmacy services became available to them under Medicare Part D. Effective 7/1/2003, the income limit changed to 116% of the FPL for a household of one person and 100% of the FPL for larger households. The resource limit was twice the SSI standard for a one or two person household ($4,000 or $6,000). Since MPAP certifications were made at MDH, these recipients were on MMIS and not on CARES.

S10 Discontinued 6/1/2006: QMB and MPAP

Beginning 10/1/2002, all Qualified Medicare Beneficiaries (QMB) (see S03) were automatically enrolled by MDH in MPAP (see S09 history). They were assigned to coverage group S10 on MMIS. With the implementation (1/1/2006 to 5/15/2006) of Medicare Part D pharmacy coverage for the Medicare eligible, QMBs in coverage group

S10 were moved to S03 when their enrollment in a Medicare prescription drug plan (PDP) was confirmed by MDH.

S11 Discontinued 7/1/2006: Transitional Emergency, Medical and Housing Assistance (TEMHA) and MPAP

Coverage group S11 was generated by MMIS to identify TEMHA (now TDAP) recipients who were enrolled in MPAP. Enrollees in the Temporary Disability Assistance Program (TDAP) who qualified for PAC moved to the S09 coverage group on MMIS. These recipients appeared as "GA" on CARES.

S12 Discontinued 7/1/2006: Family Planning Program (FPP) and MPAP

With the implementation of the Primary Adult Care (PAC) Program (see S09) on 7/1/2006, women eligible for both FPP and PAC were permitted to enroll in one program or the other but not both concurrently. Previously, women who were eligible for both FPP and MPAP (see P10 and S09) could participate in both and were assigned this single coverage group code in MMIS.

S13 Discontinued: Accelerated Certification of Eligibility

Individuals were temporarily placed in this coverage group when they were granted an accelerated certification, pending final determination in a different coverage group.

S15 Discontinued 12/31/2002: Specified Low Income Medicare Beneficiaries III (SLMB III) (Qualifying Individual 2—QI-2)

This group was discontinued effective 12/31/2002 when Congress repealed this benefit category. The QI-2 population included individuals whose income was at least 135% but less than 175% of the federal poverty level and whose resources did not exceed twice the SSI standard. These beneficiaries received federally matched payment of a portion of the Medicare Part B premium. No card was issued as no medical services were covered.

S16 Discontinued 1/1/2006: Maryland Pharmacy Discount Program.
[Note: **S16** is in current use for Increased Community Services program.]

The Maryland Pharmacy Discount Program (MPDP) ended on 1/1/2006 with the implementation of Medicare Part D pharmacy coverage. MPDP was implemented on 7/1/2003, under the authority of the HealthChoice demonstration waiver. At that time, the §1115 waiver allowed the creation of the Maryland Pharmacy Program (MPP), consisting of MPAP and new MPDP. MPDP helped Medicare beneficiaries with income at or below 175% of the FPL to pay for **prescriptions** covered by the Medical Assistance Program. There was no resource test. Recipients paid 65% of the MA price for the prescription, as well as a $1 processing fee to the pharmacy. To be considered for MPDP eligibility, the individual had to submit a separate application to the Maryland Pharmacy

Program. Since MPDP certifications were made at MDH, these recipients were on MMIS but not on CARES.

S17 Discontinued 1/1/2006: SLMB I and Maryland Pharmacy Discount Program (SLMB I/MPDP)

When MPDP ended on 1/1/06 with implementation of Medicare Part D, recipients in coverage group S17 on MMIS were reassigned to S07. Previously, beginning 7/1/03, persons who were eligible for both SLMB I (see S07) and the Maryland Pharmacy Discount Program (see S16) were assigned to coverage group S17 on MMIS. Since S17 was generated by MMIS, these recipients appear as S07 on CARES.

S18 Discontinued 1/1/2006: SLMB II (QI-1) and Maryland Pharmacy Discount Program (SLMB II/MPDP)

When MPDP ended on 1/1/06 with implementation of Medicare Part D, recipients in coverage group S18 on MMIS were reassigned to S14. Previously, persons who were eligible for both SLMB II (see S14) and the Maryland Pharmacy Discount Program (see S16) were assigned to coverage group S18 on MMIS. Since S18 was generated by MMIS, these recipients appear as S14 on CARES.

Parents and children in Long-term Care

T01 TCA Adult or Child in Long-term Care
Effective 1/1/2014, no TCA coded individuals in MAGI groups.

When an adult or child receiving TCA (formerly coverage group F01) was placed in a long-term care facility (LTCF), Medical Assistance paid the cost of care in the facility and covered their other medical services. The coverage exists, but due to the de-linking of Medicaid from TCA, adults in LTC will apply using the L-track.

Aliens

X01 Discontinued 12/1/2009: State Funded Aliens – Children and Pregnant Women

Effective 12/1/2009, Maryland began operating under the 2009 federal law lifting the 5-year bar to Medicaid or CHIP eligibility that had been imposed on legal permanent residents (LPRs). The existing beneficiaries of the former state-funded program were transferred to appropriate P-track coverage groups, and the new Medicaid-eligible 19 and 20 year olds to F98. At the same time, the X01 group was closed to new applicants. Now pregnant women with income up to 250% FPL and children up to age 21 with income up to 200% FPL, who are lawfully present, can qualify for MA services; and such children up to19 with incomes up to 300% FPL can qualify for CHIP services. *See* DHS FIA AT 10-14 (11/12/2009).

The X01 coverage group had also been used for disaster assistance. Between 9/1/2005 and 1/31/2006, applications were taken under coverage group X01 from Hurricane Katrina evacuees. Before 11/1/2005, such applicants were approved for a one-time-only

certification period of 4 months. Individuals who applied on or after 11/1/2005 were approved for a certification period of 5 months. They were covered for all Medical Assistance services on a fee-for-service basis. Federal claiming was done through a special waiver. (See DHS FIA ATs 06-11 – 06-15 and 06-20.)