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

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RE: MEDICAID EXPANSION QUESTIONS AND ANSWERS

PROGRAM AFFECTED: MEDICAL ASSISTANCE

ORIGINATING OFFICE: OFFICE OF ELIGIBLITY SERVICES

The attached pages contain responses to questions raised by Local Health Department (LHD) and Local Department of Social Services (LDSS) staff regarding the Medicaid Expansion, also called Medical Assistance for Families or "MA4F." These questions were collected at Medicaid Expansion training sessions, LHD quarterly briefings, and received from staff inquiries to the MAExpansion@dhmh.state.md.us e-mail address. Except when unclear these questions are written as received.

1. **What is MA4F? Is this different than Medicaid?**
   MA4F is Medical Assistance for Families and is synonymous with Medicaid Expansion. Although different terms are used to describe the program, the program is called Medical Assistance for Families.

2. **Can the MCHP application still be used?**
   We will be taking the Maryland Children's Health Program (MCHP) application out of circulation, but we will accept it (or any other application) if someone submits it. However, if the MCHP application is being used for a parent/caretaker relative, the case manager will need to make sure the parent/caretaker relative provides additional information such as absent parent information and reviews and signs the new rights and responsibility section at the end of the application. In such a case, the case manager could ask the parent/caretaker relative to complete the supplemental application which we created for this purpose.

3. **Are Medicare recipients eligible for HealthChoice?**
   No, Medicare recipients are not eligible for HealthChoice, but may be eligible for "fee-for-service" Medical Assistance coverage.

4. **Will the new application be used at the LHD as well as at the LDSS?**
   Yes, the new application should be used at the LHD as well as the LDSS.

5. **Who will handle the processing of coverage for retroactive months?**
   The LDSS can process spend-down and retroactive applications. The LHD can only process non-spend-down retroactive applications.

6. **When will CARES be updated to appropriately accommodate the new changes for the expansion?**
   The CARES programming necessary to increase the effective eligibility standard and to eliminate the assets test is complete (effective July 1, 2008). Additional programming changes, including the trickling for the earnings and child support extensions were migrated on August 25, 2008. Programming changes necessary to allow for declaratory child care expenses was migrated in December 2008.

7. **Is income declaratory?**
   Yes, unless the caseworker concludes that documentation should be required for a particular case. Self-employment income must be verified since this type of income is not available on MABS.

8. **Will citizenship and identity still have to be documented?**
   Yes, this federal requirement has not changed.

9. **What documents (besides the proof of identity and proof of citizenship) will be "ABSOLUTELY" necessary to submit with an application under the new policy?**
   When submitting an application no additional verification is required, although the case manager may make a request to verify questionable information or provide additional information.

10. **Will the ABD income standard change?**
    No, the ABD standard will remain the same.

11. **Will dropping health insurance affect FAC?**
    No. Eligible families can receive MA regardless of whether they have other health insurance.

12. **Will the Managed Care Organization (MCO) process change?**
    There will be no change in the MCO enrollment process.

13. **If an application is received for MA only (F05) in the LDSS, should the case be sent to the LHD?**
No, the case should be processed at the office in which it was received.

14. **Will the LHD send cases to the LDSS if there is an associated case?**
Yes, the Accelerated Certification of Eligibility (ACE) process is still in effect.

15. **Will F05 applications completed at the LDSS be transferred to the LHD?**
No, the F05 case will remain in the LDSS or LHD that completed the application.

16. **Pregnant women only, pend in F05?**
No, as long as there are no dependent children, pregnant women should be pended only in P02. Please refer to action transmittal #08-32 for additional information.

17. **Is expansion only for the F-track?**
DHMH is expanding eligibility only for the F-track (low income families) as of July 1, 2008.

18. **Is an asset test still required for the F-track?**
The asset/resource test will only be required for the F98 and F99 (medically needy) coverage groups.

19. **How will assistance units be pended, all pended in F05?**
If a parent/caretaker relative with dependent children is applying for themselves along with their dependent children, then the entire assistance unit must be pended in a F05 coverage group. If an applicant is pregnant and is the only household member applying, then she must be pended in a P02 coverage group. If a parent/caretaker relative with dependent children is only applying for the children, then the children must be pended in the applicable P-track category.

20. **Why do clearances have to be completed when income is declaratory?**
The clearances (MABS, SVES, etc.) are required by Federal regulations and are to verify that what the customer indicated on the application is true.

21. **If a customer indicates that they are not employed and earnings are listed on MABS, does verification have to be requested?**
Yes, this is required to verify the facts to determine eligibility.

22. **If case worker/manager at the LDSS or LHD decides additional information is needed, how will the client/representative be notified and how long will they have to return the information?**
The client/representative will be notified in writing if the case manager at the LDSS or LHD determines that additional information is needed. If the case is with the LDSS, the client will generally be given 10 days to return the requested

information. If the case is with the LHD, the client will generally be given 5 days to return the requested information.

23. **If a discrepancy exists and additional information is requested and not provided, can the case be closed?**
Yes, if the requested information is not provided, then the case should be denied or closed.

24. **The income standard is tied to the Federal Poverty Level, will this change every year?**
The income standard (the dollar amount which must not be exceeded by a family of that household size) is based upon 116% of the Federal Poverty Level and it will change each year after U.S. Department of Health and Human Services releases its annual update of the federal poverty guidelines. This happens during the first quarter of the calendar year and will be communicated with the local departments.

25. **Do changes have to be reported during the certification period?**
Yes, always, a recipient must report any changes to income or household status within 10 days of the change.

26. **What limits will be applicable for retroactive, spend-down applications submitted July 1, 2008?**
Pre-expansion eligibility standards for spend-down applications will remain in effect until October 1, 2008 for some applications. After October 1, 2008, new spend-down standards will apply. Please refer to Action Transmittal 08-32 and CARES Bulletins 98-06, 02-16, & 96-52 for additional information.

27. **With the income changes in effect July 1, 2008, what if a current spend-down application is now eligible for F05 under the MA for Families initiative?**
If a recipient in M status for a F99 AU (after 7/1/08) contacts the LDSS for any reason, the LDSS must conduct an unscheduled MA redetermination because the spend-down household may become eligible for MA as a result of expansion. If the customer's income is below the income standard for the **F05** AU, the F99 AU should be processed in Option X,(Spenddown Authorization) to determine if recipients will be eligible for MA under Spenddown prior to 7/1/08. After determining Spenddown Eligibility, then the Spenddown should be closed, (559 code in the client RSN column) for the months after 7/08, and the household must be determined eligible in the **F05** AU. Remember to change the certification period end date on the CARES MAFI screen to match the original F99 AU certification end date.

28. **Who is putting the bills on for spend-down?**
The LDSS will be receiving and entering medical bills on CARES.

29. **Who handles spend-down?**
    All spend-down cases are handled by the LDSS. Please refer to Action Transmittal 08-32, and CARES Bulletins 98-06, 02-16, & 96-52 for additional information.

30. **If an application is submitted to the LHD and it is transferred to the LDSS because it trickles to, or because there is an associated cash assistance or food stamp case, how will the client or the Authorized Representative be notified for follow-up?**
    For persons certified under the ACE process because of an associated cash assistance or Food Supplement Program (formerly the Food Stamp Program), the LHD will send the customer a letter notifying them of the three month certification period, which includes the information that this period is unaffected by a denial by the LDSS and that the case has been forwarded to the LDSS.

    For cases trickling to spend-down, the LHD case manager will send a letter to the customer or authorized representative notifying them that the case has been transferred to the LDSS. The LHD case manager will send CARES notice 0118 requesting that the customer complete and return the notice (0118) and provide verification of assets to the LDSS, if applicable.

31. **Is a social security card required for all applicants?**
    Although the actual card does not need to be provided, it is a federal requirement that all applicants **must** provide a social security number.

32. **Do we require proof that someone applied for a social security card?**
    No, but the social security number **must be** verified at the first scheduled redetermination in order to continue eligibility.

33. **Do we still need proof of child care expenses? How will this be handled in CARES?**
    In order to allow the deduction for F05, child care expenses had to be verified until CARES programming was complete in December 2008. For P-track cases, CARES allows the deduction without the verification.

34. **For health care insurance, is a copy of the front and back of the health insurance card required?**
    Yes, but do not deny application if a copy of the health insurance card is not received and if sufficient health insurance information is provided on the application.

35. **What happens if the grandparent who is a caretaker relative wants to come on MA as a result of expansion and currently has Medicare coverage? What is the coding for Medicare coverage?**
    Determine eligibility in F05 category. Select Medicare Part A on the CIRC screen. Code CARES DEM2 screen "Entitle Med A" field "Y" and enter the social security claim number in the "Claim Number" field on the CARES UINC

screen. The grandparent with Medicare coverage would not be enrolled in HealthChoice, but would be eligible for "fee-for-service" Medical Assistance coverage.

36. **If the information regarding child support on the application is different than the information retrieved from the child support screens, what should the case manager do?**
The case manager should determine eligibility based upon what is verified by the child support screens. The child support information is verified by the Child Support Enforcement Administration.

37. **What if an applicant declares income, but the information is not on the Maryland Automated Benefit System (MABS)?**
Request verification of earned income.

38. **Are redeterminations processed any differently than pre-expansion redetermination applications?**
No, redeterminations are processed the same. Please refer to action transmittal #08-32 for additional information, including information about unifying families in the F05 coverage group.

39. **Will redeterminations take place in the office where the applicant originally applied?**
Redeterminations will be completed in the office where the case is currently active, which is listed on the CARES notice sent to the customer.

40. **If an application is received in a LHD and there is a pending MA application in an LDSS, what action is to be taken by the LHD?**
Apply the ACE process and transfer the application to the LDSS.

41. **Is a faxed affidavit acceptable?**
Yes, a faxed affidavit is acceptable.

42. **What is the date of application?**
The date a signed application is received at the LHD or LDSS.

43. **Is verification of citizenship and identity required for ACE processing?**
Documentation of citizenship and identity is required to complete the ACE process.

44. **A mom is applying for her 2 children only. Child "A" is already active under P13 category. Child "B" is not active and has a P07 case that ended 2-29-08. Would child "B" be pended under the F05 category or would the closed P07 case be reopened for that particular child. If the mom was also applying for benefits in this case would we shut down child "A" P13 and pend the whole family unit under the F05 category?**
Since the mother is applying for her children only and not herself, the P07 case

would be reopened. If the mother was applying for MA, then she and the child for whom she is also applying would be pended in a F05 category. The active case for child "A" would not be closed because the child is active in a P13 category. The child that is active in the P13 category should be coded as AC (financial responsibility field) on the STAT screen for the P07 or F05 applications.

45. **If a parent is applying for MA Expansion for self and children the F05 category should be pended. If a parent is applying for children only, then the children should be pended in the P-track. True or False?**
True, if a parent is applying for self and children, then the family should be pended in a F05 category. If a parent is applying for children only, then the children should be pended in a P-track category.

46. **A mom is applying for MA Expansion for herself and child (ren). Mom is not pregnant. Mom has an active Food Supplement Program (FSP) case at a LDSS. This case is usually ACE. Should an F05 be pended for mom and children and should the 3 month ACE process be done for all family members or do you follow the same ACE rules of pending P track for children only? Or should it be forwarded to the client's local DSS Office?**
If an applicant is applying for her and her children and has an active FSP case in another district, then the entire family should be pended in an F05 and eligibility should be determined using the ACE process for F05 and P-track coverage groups. The income standards for both the F05 and the applicable P-track coverage groups must be considered before forwarding case to the LDSS and to DREP.

47. **A mother and father are applying for themselves and their children. All members of the family are permanent residents who have not met the 5-year residency guidelines for MCHP. Would the mom and dad be able to apply in the F05 category?**
Everyone has the right to apply for benefits, however, the F05 coverage group would not be applicable. The citizenship guidelines, which apply to all Medical Assistance, including MCHP, have not changed. Only the children may be considered for the X01 coverage group, unless the mom is pregnant, and then she may also be considered for the X01.

48. **If the mother and stepfather (not the biological father of child) of a child is in the household and the stepfather wants to apply for MCHP benefits, would he be able to apply?**
The stepfather can apply for MCHP, however he would not qualify. Eligibility for the stepfather along with the entire household should be determined in the F05 Medical Assistance category.

49. **If a customer is pregnant and needs dental services, would these services still be covered in a F05?**
Yes, the customer should contact her MCO to find a dentist. If the MCO fails to

help her find a dentist, then the customer should contact the MA hotline number at 1-800-284-4510.

50. **How much does a recipient have to pay for prescriptions?**
The maximum amount that a person would have to pay is $7.50 for the PAC program and $3.00 for HealthChoice. Children under 21 years, pregnant women, individuals in the hospice program, and individuals in nursing homes or other institutions are exempt from co-payments. In addition, family planning drugs and devices are exempt from co-payments.

51. **When an application is received for Mom, Dad, daughter age 19 and 4 other children active in P07, do we keep the MCHP open for the active P07 children? The income of the household was calculated and it was determined that the household is over scale for F05. Are the children still eligible for MCHP?**
Since the F05 AU is ineligible due to excess income, leave existing P-track AUs open. The F05 will trickle to F99 for the mother, father and 19 year old. When finalizing the F99, code the active P-track children "AC" on the STAT screen.

52. **When an LHD receives an application and retroactive coverage is requested for the months of April, May, or June 2008 and the case does not trickle to a F99 coverage group, what action is required by the LHD? The LHD has not been trained to determine eligibility under the F05 coverage group using the pre-Medicaid expansion rules.**
The LHD must request verification of assets, income, and medical bills. If assistance is required in determining retroactive eligibility for April, May, or June 2008, please contact the Division of Eligibility at 1-800-492-5231, select option 2 and request extension 1463.

53. **Are health insurance payments included as part of the child support deduction?**
No, health insurance payments are not included as part of the child support deduction.

54. **When a redetermination or interim change causes a P-track (MCHP) case to close, should the case manager determine eligibility in another coverage group?**
Yes, the case manager should determine eligibility in the F05 coverage group for the household member whose coverage was closed. Please refer to action transmittal #08-32 for additional information.

55. **When a Case Information Form (CIF) is received for a current P-track (MCHP) redetermination, should the LHD and LDSS determine eligibility for the household in the F05 coverage group?**
The LDSS and LHD are encouraged to contact the parent/caretaker relative and ask the parent/caretaker relative, who is not receiving MA, if they would like to apply for MA. If the parent/caretaker relative indicates yes, then a supplemental

application for Families, Pregnant Women, and Children must be mailed to the parent/caretaker relative. Upon receipt of the supplemental application, eligibility should be determined in the F05 coverage group. If the parent/caretaker relative indicates no, then process the MCHP redetermination. Please refer to action transmittal #08-32 for additional information.

56. **When a CIF is received for an F98 coverage redetermination, should the LHD and LDSS pend and determine eligibility in the F05 coverage group?**
Yes, the LHD and LDSS must close the F98, then pend and determine eligibility in the F05 coverage group.

57. **Is verification of pregnancy required for the F05 coverage group?**
No, verification of pregnancy is not required for Medical Assistance.

58. **Currently, the 9701 (pink application) is sent to pregnant women whose MA is due to expire. Will this form still be sent or will the new MA application be used?**
Yes, the 9701 will be sent to pregnant women whose MA is due to expire.

59. **If the 9701 is still sent, can the LHDs use it to process F05 or will we have to have the client complete the new MA application?**
Yes, the LHDs can use the 9701, if received, to process an F05 for any applicant or recipient.

60. **I have an application for Family Medical Assistance for a customer who has two children; one has turned 19 years old and lost coverage on 06/30/08 and another who is currently a P14 in MCHP. How do I proceed with this case because if I close the P14, I cannot open her in F05 until 08/01/08 and the older child will not have coverage in 07/08. If I pend the family in F05 for 07/08 and close the case with code 507 for the younger child will I lose the link between younger child and other family members? I realize that they will probably be over scale income for F05; however, as I have the application I need to process it.**
The entire family should be pended in F05 for 07/08. The P14 case should remain active. The P14 child should be coded AC on the F05 STAT screen.

61. **I received one of the new applications date stamped 6/30/08. The customer is applying for herself, husband, and 2 children. The children are up for their redets also. How do I do this? Do I do the redet and add-a- program for the F05? Do we close the two P07's and open everyone under F05?**
Since the application was filed on 6/30/08 instead of 7/1/08, it was known prior to finalization that the case will trickle to F99, the following action should be taken:
Pend entire family in F05
Code active P-track children AC on the F05 STAT screen
Finalize F05, which will trickle to F99
Complete option X "Spndown Authorization"

62. **We are trying to process an F05 for a family.**
Mother (HOH) - permanent resident with less than five years since entry.
Father - U.S. Citizen
Child 1 & 2 - Undocumented alien
Child 3 & 4 - U.S. citizen
On the STAT screen, in the FINL RESP field, we tried to code the Mother and Child 1 and Child 2 as 'EA' but received the message that this is not an appropriate code. We then coded everyone as PN and on the DEM2 screens we coded the mother and Child 1 and Child 2 as 'I' for the Citizenship code and the Father and Child 3 and Child 4 as 'C'. When we finalized the case, this resulted in Father, Child 3 and Child 4 being approved for F05 and Child 1 and Child 2 being denied with code 202. The Mother showed Status code of 'A' but had code 202 next to her name. The income calculations were correct and the income limit was correct for a household of six. When we went back into the case through 'R', only the Mother, Father and Child 3 and Child 4 were still on the STAT screen. Is this the correct way to process this case? When the CIF is created for redetermination, Child 1 and Child 2 will not appear on the form.
The process that you described is correct. Remember that there is a difference between Status Codes and Finl Resp codes. All HH members will appear on the STAT Screen with a Status Code of "A"- including Finl Resp Codes of "NM". A Status Code of "A" does not mean that a person is receiving benefits.

63. **My customer has a child in common with her boyfriend. They all live in the same household, the child's father receives SSA and SSI and the child receives SSA. How I should code child's father on the stat screen?**
If the father is currently active in an S02 category in CARES, he should be coded "PN" for the Finl Resp on the STAT screen. During finalization, CARES will change the SSI father's Finl Resp code to SI with a denial code of 203.

64. **We have an application from the client, who delivered 06-03-08. She is applying for the entire family, including the newborn, which is active under the P03 track with eligibility until 08-09. I need to know, should we just pend and work the case for the mother and her oldest child and leave the active P03 case alone or process the newborn under the F05 case?**
Pend the entire household in F05 and determine eligibility. Close the P03 with a code of 507. Document in the case narrative the P03 child's eligibility. Remember to reopen the P03 child in the P06 category if the child loses eligibility within the 15 month eligibility period.

65. **How are we supposed to pend cases in CARES. Are we supposed to pend all cases under the F05 track unless it is a pregnant woman?**
If parents/caretaker relatives with dependent children are applying for themselves along with their dependent children, then the entire assistance unit must be pended in a F05 coverage group. If an applicant is pregnant and is the only household member applying, then she must be pended in a P02 coverage group. If a parent/caretaker relative with dependent child(ren) is only applying

for the child(ren), then the child(ren) must be pended in the applicable P-track category.

66. **When the agency receives the 958 alert from Child Support indicating that the customer has failed to cooperate with Child Support, what reason codes are the worker's supposed to use in order to cancel the MA for the parents? Is this the code that is to be used for F05 as well?**
The 505 reason code is for TCA only. The code that you would use for non-cooperation with child support is 566, non-cooperation with eligibility process. Add a text to the notice indicating the following "You did not cooperate with child support as required by COMAR 10.09.24.15."

67. **The entire family is applying for health coverage. We have pended an F05 case. We have all the documentation to verify citizenship and identity for everyone except one child. What would we do with this case? Would we process the family members that have their documentation for citizenship and identity and deny the one child or deny the entire family until the citizenship and identity information is received for the one child?**
You would process the family members who have their citizenship and identity documentation and deny only the child that does not have citizenship and identity verification.

68. **We have an application where the client is applying for the grandchild, but not herself. The client's daughter is 17 years old. The grandchild is the client's daughter's child. I need to know if the client's daughter can apply for herself and her child without the mother, even though she is under 21 years old?**
Eligibility would be determined in the P-track because the grandmother is not applying for herself. Although the client's daughter can file an application, eligibility cannot be determined until the grandmother signs the application and completes the application process. The grandmother can apply for both. Code the grandmother IP for the daughter's case. Code the grandmother NM and the minor mother IP for the grand daughter's case.

69. **I have a family that is applying under an F05 case. Some of the members in the family have their citizenship and identity but two members don't. I know we will process the members that have their citizenship and identity and deny the members that don't. When the member sends in the documentation to verify their citizenship and identity, do we pend another F05 case?**
When a denied household member sends in his or her citizenship and identity documentation you would complete Option K (Add-A-Person) in CARES to add the household member to the existing F05 AU. Do not pend another AU.

70. **If we have someone apply for an F05 category who is currently in a P10 track (Family Planning) and we deny her eligibility and she trickles to an F99 track what happens to her P10 coverage?**
The P10 coverage will remain active unless the customer meets spend-down and becomes active in the F99 coverage group.

71. **If we receive an F05 application and there is an absent parent involved for the case, but the HOH doesn't give us this information (Section is blank) on the application, do we deny the adult on the case or do we put unknown in the CARES system and approve everyone? Or, do we try to reach the HOH and if unable to reach them for clarification, deny the F05 and approve the children in a P-track?**
If the applicant does not list the absent parent information on the application, then you should contact the applicant and if you are unable to reach the applicant, request verification in writing. If the applicant does not respond and is otherwise eligible, you would approve the application. Review the new Medical Assistance/Maryland Children's Health Program for Families, Pregnant Women and Children application to ensure that it is signed prior to determining eligibility. The signature on the application indicates that the applicant agrees to the assignment of support rights provision. Code the absent parent field on the CARES APID unknown. This will generate a referral to Child Support Enforcement Agency (CSEA) who will determine if the recipient is in compliance with child support. If the recipient is not in compliance with child support, CSEA will notify you via a CARES alert.

72. **We were told that if we have a Pregnant Woman and her children opened in an F05 category that we should add the newborn when we receive the 1184 to the case as a P03 through add-a-program. Is this correct? If so, do we also add this child to the F05 siblings/parent/caretaker relative AU at the same time? If so, how do we code everything? If we don't add the baby as a P03 and we give the baby eligibility through the F05, do we need to verify citizenship and identity or is the 1184 sufficient verification?**
No, this is not accurate. In the situation that you described, the newborn should be added to the F05 by selecting Option K (Add A Person) on the CARES AMEN screen. The 1184 is sufficient verification for citizenship and identity for the first year of eligibility, then citizenship and identity must be verified. Remember to re-open the P03 child in the P06 category if the child loses eligibility within the 15 month eligibility period.

73. **I approved a husband and wife for F05; the CARES STAT screen shows they are both active recipients. The letter the client received only lists the husband as approved. I checked MMIS and he is active F05, but she is still active P10. Is this going to be an on-going process of having to send a CTAD to correct coverage?**
You are not required to send a C-TAD to correct the coverage group. Once the case is finalized in CARES, it takes approximately 48 hours to display on MMIS.

74. **If the parents' permanent resident cards indicate they have been in that status for less than 5 years, are they eligible for expansion? What if the mother has met the 5 year bar, but the father is not?**
The policy regarding alien eligibility has not changed. If adult applicants have not met the five year bar, then they are not eligible for Medical Assistance, except as an X02. If the mother has met the five year bar then she would be potentially eligible for F05 and if the father has not met the five year bar, then he would not be eligible for F05.

75. **For clarification, we were advised in the quarterly staff meeting to:**
Pend in P track if application is marked as only children applying
Pend in F track if application is marked as adults and children applying
Pend in F track if application is not marked who is applying.
Do we use the boxes on the instructions/information page to determine the applicant's choice or do we use the information within the application?
The application cover sheet contains facts for the applicant and is not required to be submitted as part of the application. The boxes on the cover sheet are not the determining factor. As stated at the MCHP quarterly on 6/26/08, the determining factor is listed on page one of the application in the section entitled "applying for Medical Assistance/MCHP." Eligibility should be determined based upon what is indicated in these boxes. If it is not indicated on the application who is applying, then you are encouraged to contact the parent/caretaker relative and ask who they are applying for. Use the following as a guide to determining eligibility:
If a parent/caretaker relative with dependent children is applying for him or herself, along with dependent children, then the entire assistance unit must be pended in a F05 coverage group. If an applicant is pregnant and is the only household member applying, then she must be pended in a P02 coverage group. If a parent/caretaker relative with dependent child(ren) is only applying for the child(ren), then the child(ren) must be pended in the applicable P-track category.

76. **I have a mom that wants to apply for her son who is in the Army and stationed out of Maryland. Can she still apply for him, and if he meets age and financial requirements, would he be eligible?**
Yes, the mom can apply as long as the child is still considered her dependent and verifies Maryland residency. This can be verified by the current tax return of the parent and/or child. If residency is verified and the child meets the age and financial requirements, then the child would be eligible.

77. **I have a 65 year old grandmother who wants to apply for her two grandchildren and herself. She doesn't have Medicare yet and she hasn't done any paperwork for Medicare. Can she qualify for F05?**
The grandmother must provide proof that she has applied and taken all the necessary steps to obtain and accept all income benefits to which she may be entitled, which includes Medicare and SSA benefits. Request that the applicant apply for Medicare and SSA benefits and provide you with proof prior to determining eligibility in the F05 coverage group. If the grandmother fails to

return the requested verifications timely, deny the F05, and the case will trickle to the appropriate P track.

78. **The transmittal does not make clear how we are to handle conversion from MCHP to MA expansion. When the MCHP application is mailed in and it has no child support information included, how should this be handled?**
The new Medical Assistance/Maryland Children's Health Program for Families, Pregnant Women and Children application contains a section to list child support information. If the previous MCHP application is received and child support information is required, then use the supplemental application.

79. **How are we supposed to handle MCHP mail in redets? When customers mail-in the information they do not provide the child support information needed to test for F05. What about the time frame to repend? Do we know that this group is aware of this new expansion? TCA applicants who have been denied should also be pended as F05 if they have provided citizenship/identity/child support information? Has anyone looked at the # of repended cases the above will generate for the workers?**
When a mail in redet is received, you are encouraged to contact the parent/caretaker relative (P/CR) and ask the P/CR, who is not receiving MA, if they would like to apply for MA. If the P/CR indicates yes, then a supplemental application for Families, Pregnant Women, and Children must be mailed to the P/CR. You should give the recipient 10 days to respond. Upon receipt of the supplemental application, eligibility should be determined in the F05 coverage group. If the supplemental application is not received, then the MCHP redetermination should be completed. If the information is received after the case is closed, then the tardy redetermination procedure should be followed. The Office of Planning has done a lot of outreach regarding the new Medical Assistance for Families and Children program. This outreach has included newspaper articles, town hall meetings, and the creation of a new DHMH web page: http://www.dhmh.state.md.us/ma4families/index.html.
Since denied TCA applications will trickle to an F05, no repending is required. Case manager must determine eligibility in the F05 coverage group.

80. **The customer was active TCA and reported that his SSDI was approved. He is receiving $1073 per month and received a retroactive payment (lump sum) of $27,000 in May. He has $15K left in his bank account after paying lawyers, etc. Does his lump sum count as income and need to be prorated over six months (or until the end of the original TCA cert 7/08)? Or does it not count as income because it's past the month of receipt, but does count as a resource? Would it be coded as lump sum on the AST1 screen or something else? The wife's name is also on the bank account that has the $15K. Does that mean that she is ineligible also?**
Since the month of receipt has passed, the lump sum is not counted as income, but is counted as a resource if the case trickles into spend-down. Since the wife's name is listed on the bank account and if she has access to the account, then it would be counted as a resource if the case trickles into spend-down.

81. **If we deny a recipient in an F05 for a technical reason (557), i.e., failure to provide information, etc. does he or she lose P10 (family planning) coverage?**
If a recipient is currently active in the P10 coverage group, applies for and is denied for any other MA coverage group, then the recipient would not lose his or her P10 coverage.

82. **We have an F05 case with a mother, father and one child in common. They are only applying for the mother and child. How do we code the FAC spouse since he doesn't want coverage and we need to include his income? Can we code him as an AC or must we use PN even when he doesn't want coverage?**
The father must be coded as IP (Finl Resp) on the CARES STAT screen and his income will be counted.

83. **If a client calls and makes a request to withdraw their case for any reason do we need something in writing or can we use a verbal request?**
Request that the applicant/recipient provide you with a written statement.

84. **If we have a case where there is self-employment and they provide their income tax return, but state that their income is much lower due to economic turndown, do we need something in writing from their tax preparer or will a letter signed by them suffice? If we deny a recipient in an F05 for a technical reason (557), i.e., failure to provide information, etc. do they lose their P10 coverage?**
Tax and business records are the primary source for verifying self-employment income. If the customer indicates that income is much lower due to economic downturn, then documentation from the tax preparer would be sufficient. Tax records should be obtained at the next redetermination to verify that what was previously provided was true. A letter signed by the applicant would not be sufficient. If a recipient is currently active in the P10 coverage group, applies for and is denied for any other MA coverage group, then the recipient would not lose their P10 coverage.

85. **How will the expansion program affect X01 and X02 coverage. Is there or will there be X01 and/or X02 coverage for non pregnant adults?**
The F05 coverage group has always included both parents and their children. The rules for X01 and X02 eligibility have not changed. X01 is only for children and pregnant women who are legal permanent residents who have not met the 5-year bar. X02 is for persons who are otherwise eligible non-qualified aliens. Individuals that are eligible for X01 and X02 do not meet the citizenship/immigration status requirements for coverage under the F05 coverage group.

86. **Does the elimination of the face-to-face interview also extend to the ABD category?**
Not at this time.

87. **Does all declaratory information that pertains to the FAC category also apply to the ABD category?**
The new regulations regarding declaratory income is only for the Families and Children coverage groups, not the ABD category.

88. **Mother, father and children open in F05. The mother reported that she and the children left the household. I removed the father from all the AU's eff. 6/30/08. The system is removing the mother from the AU eff. 7/31/08 with a 211 code (parental status change required). In the notice, I advised the customer that to continue to receive MA for herself she would need to apply for child support before the end of 7/08. Is this correct?**
The customer does not need to apply for child support in order to be eligible for medical assistance. But, the customer must agree to assign support rights and to cooperate with the child support enforcement agency before eligibility can be established. The new application has this information on the "Customer Rights and Responsibilities" page. (Note: If a parent in an intact HH is removed, the children's parental status codes need to be changed from "N" to "A". Otherwise the remaining parent will change from "RE" to "IP" with 211 reason code.

89. **Are we going to be completing PAC applications?**
No, PAC case managers complete PAC applications.

90. **Will the application generated by CARES for MA/MCHP redets include the child support questions?**
Currently, the CIF (Client Information Form) that is generated for redets will not have the child support/absent parent information. For now, we encourage the case manager to contact the parent(s) and ask if the parent(s) would like to be considered for medical assistance. If so, send the supplemental application to be completed with the information regarding the absent parent(s).

91. **We have not had training on assets and the new applications do not request asset information. How do the LHDs handle requests for F05 retroactive coverage for 04/08, 05/08, and 06/08.**
Unless the retro months are in spend-down, everyone, including the LHDs, must handle the retro months of 4/08, 5/08, & 6/08 according to the pre-expansion rules. This means that all assets must be considered and counted for the F05's, and medical bills must be received before eligibility can be determined. If you are unsure as to what to ask for please call the Division of Eligibility Policy at 410-767-1463 or 1-800-492-5231 (select option 2 and request extension 1463) and you will be directed to a policy specialist who will assist you.

92. **What category should the screeners use if the customer files one of the new applications and requests coverage for the children (under 19) only. Should the coverage group be F05 or one of the P-track categories?**
If the customer is only applying for children under 19, the case should be pended and processed in the "P" track.

93. **If there is an application for mom, dad, daughter age 19, and four other children are on MCHP, is everyone on STAT screen coded PN (financial responsibility field)? Do we keep the MCHP open for the children that are currently active in a P07?**
Yes, everyone is coded "PN" on the STAT screen. If the household is eligible for F05 coverage, then close the P07 AU with a code of 507. If the F05 AU is ineligible due to excess income, then leave the existing P07 AU open.

94. **When someone applies for Medical Assistance after July 1, 2008, will the new rules extend back to cover the retroactive period? It is expected that the increased income will not be retro, but can you still eliminate the face-to-face interview for retro coverage? Will the declaratory provision exist for the retro coverage back to April for July applications?**
Medical Assistance for the retro months of 4/08, 5/08, and 6/08 will be determined under the old FAC rules, however the face-to-face interview will not be required since the person is applying on or after July 1, 2008. Income and assets must be verified for the retro months.

95. **If there is no spend down needed, will the coverage period be for one year from the date of application, or filing?**
If the case is not a spend-down case, the normal certification period is 12 months from the date of application.

96. **What is the difference between reactivation and reinstatement?**
A reactivation is for applicants. When a customer has been denied (usually for not returning all of the requested information), and then, within 6 months of the application date does return all of the information needed to determine eligibility, the case manager will reactivate the case (will re-screen the denied AU) and determine eligibility.
A reinstatement is for recipients. If the case manager closes a case but before the closing date occurs the customer provides information that negates the reason for the closing, the case manager may reinstate the closed AU. But remember that you can only reinstate a case before it is actually closed. Once the case is closed on CARES, if there has been an error or for some other reason the customer is now eligible, the case must be re-pended.

97. **What is the difference between agreeing to assign support rights and applying for child support?**
The main difference between TCA eligibility and MA eligibility is that to be eligible for TCA the customer must apply for child support. But for MA eligibility the customer must just agree to cooperate and apply. They do NOT have to apply for child support or cooperate with child support to be initially eligible for MA.
If the child support enforcement agency later sends an alert through CARES that the customer has failed to cooperate, the case manager would close the adult's MA case.

98. **In the past the LHDs have only processed children and pregnant women for emergencies in the X02 coverage group. Will the LHD's now be processing application for all adults with approved emergencies?**
If they would be eligible for F05 if they were citizens, then yes, you would determine their eligibility in the X02 track, using F05 rules and standards. But remember, only the person with the emergency condition (determined by OES, not the case manager) is eligible, not the entire household.

99. **If a person is self-employed and purchases health insurance coverage for the family from a private entity, if they meet all eligibility criteria, are they eligible in the expansion program without a penalty if they drop that private insurance?**
Yes, eligible families under the F05 coverage group can receive MA regardless of their health insurance status. P13 and P14 are the only coverage groups in which an applicant may not be covered by an employer-sponsored health benefit plan or have been voluntarily terminated from such a plan within 6 months before the application date.

100. **What is considered questionable or discrepant information?**
If information is considered questionable or discrepant, then request verification to clarify the questionable or discrepant information. The following are examples of questionable or discrepant information:
   - Information on the Medical Assistance application does not match current food stamps or child support information;
   - A deficit budget exists;
   - The status of absent parent is questionable; and
   - The earned income listed on the Medical Assistance application does not does not match MABS.

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

cc: DHR Executive Staff
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Constituent Services
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