Medical Care Programs Eligibility

The following general list of eligibility groups is intended to familiarize you with the types of coverage available from Medical Assistance (Medicaid) and Maryland's other Medical Care Programs. To find out if you are eligible for Medical Assistance or other public assistance, please apply at your **Local Department of Social Services (LDSS)**. If you are applying for assistance for a child or are pregnant, you may apply for the **Maryland Children's Health Program** (MCHP) at your **Local Health Department** (LHD). If you are elderly and only applying for assistance with paying your **Medicare** premiums, co-payments, or deductibles, you may apply at your **Area Agency on Aging (AAA)**. For more information, you may call DHMH's Recipient Relations Hotline at 1(800) 492-5231 or (410) 767-5800.

Medicaid Program

Maryland Medical Assistance (Medicaid) Program

The Department of Health and Mental Hygiene (DHMH) provides Medical Assistance, also called Medicaid, coverage to individuals determined to be categorically eligible or medically needy. Medicaid coverage is automatically granted to individuals receiving certain other public assistance, such as Supplemental Security Income (SSI), Temporary Cash Assistance (TCA), or Foster Care. Low-income families, children, pregnant women, women with breast or cervical cancer, and aged, blind, or disabled adults may also qualify for Medicaid. Eligibility for Medicaid is re-determined every 12 months, except that eligibility is re-determined every six months for "spenddown" cases (See Medically Needy).

Medicaid is available to low-income persons in certain categories. Federal Medicaid laws require that every state cover certain groups. Coverage is also allowed for certain optional categories. Following is a list of the groups covered by Maryland's Medicaid Program.

Families and Children (FAC)

Low- income families with children who meet the financial and technical eligibility requirements for the State's **Temporary Cash Assistance** (TCA) Program, which replaced Aid to Families with Dependent Children (AFDC), are automatically eligible for Medicaid. To be eligible for TCA, the household's earned and unearned income cannot exceed the TCA benefit level for the household size, and the assets cannot exceed the limit for the household size (e.g. $2,000 for a household of one person). Medicaid may also be granted to families or individuals who would qualify for TCA benefits but did not apply, or who lost their TCA eligibility for one of the following reasons:

- increased earnings or hours of employment;
- loss of earned income disregards;
- increased child support collections;

- quitting a job without good cause;
- non-compliance with TCA work requirements; or
- failing another TCA non-financial requirement.

Medically needy families with children also qualify for Medicaid if their income and/or assets are greater than the TCA standards, but less than the Medicaid medically needy standards for the household's size (e.g., income less than $350 per month and assets less than $2,500 for a household of one person). Families may become income-eligible through a 'spenddown" process. (See Medically Needy)

Children Receiving Foster Care or Subsidized Adoption Services

Children receiving foster care or subsidized adoption services from the Department of Human Resources are eligible for Medicaid.

Refugees and Asylees

Medicaid coverage may be granted to refugees and asylees in the following categories:

- Recipients of Refugee Cash Assistance (RCA);

- Individuals who lost Refugee Cash Assistance eligibility due to increased earnings or hours of employment; or

- Refugees who are technically ineligible for RCA, but whose income is less than 200 percent of the federal poverty level and whose assets meet the Medicaid medically needy standards, or who become income-eligible for Medicaid through "spenddown".

Aliens

Medicaid eligibility for aliens is based on whether the alien is a "qualified" alien and whether the alien has resided in the United States as a qualified alien for five years.

- *Qualified alien* is a person who is not a U.S. citizen and is:
    - A lawful permanent U.S. resident;
    - a refugee;
    - an asylee;
    - an alien who has had deportation withheld under section 243(h) of the Immigration and Nationality Act (INA);
    - an alien granted parole for at least 1 year by INS;
    - an alien granted conditional entry under immigration law in effect before April 1, 1980;
    - an honorably discharged veteran;
    - an alien on active duty in Armed Forces of the United States; or
    - the spouse or unmarried dependent child of one of these persons.

Qualified aliens, other than refugees and asylees, may qualify for full Medicaid benefits if they have resided in the United States as a qualified alien for five years and they meet all other eligibility criteria.

- *Non-Qualified alien* is an alien who is one of the following:
  - an alien who does not meet the definition of qualified alien;
  - an illegal alien; or
  - a qualified alien who has resided in the United States as a qualified alien for less than five years.

Non-qualified aliens may qualify for Medicaid coverage of emergency medical services if they meet all other eligibility criteria.

Aged, Blind, or Disabled (ABD) Persons

Medicaid coverage may be granted to individuals in the following categories:

- Recipients of Supplemental Security Income (SSI) from the Social Security Administration are automatically eligible for Medicaid.

- Individuals qualify who lost SSI eligibility due to an annual cost of living increase in their Social Security income or a change in the federal disability definition.

- Individuals qualify as ABD Medically Needy (See Medically Needy), if they are aged, blind, or disabled and their household income and assets do not exceed the Medicaid income and asset standards for the medically needy (e.g., $350 per month in income and $2,500 in assets for a household of one person). The allowed income and assets vary depending upon family size.

- Individuals qualify through ABD Spenddown (See Medically Needy), if they are aged, blind, or disabled persons whose household assets meet the medically needy standards but whose household income exceeds the Medicaid income limit for the medically needy. The individual becomes Medicaid-eligible once incurred medical expenses total or exceed that excess amount.

- Recipients of Public Assistance to Adults (PAA) are automatically eligible for Medicaid. PAA is a state funded program through the Department of Human Resources (DHR), which supports ABD adults living in assisted living facilities, Project HOME adult foster care, or residential rehabilitation facilities of DHMH's Mental Hygiene Administration.

Institutionalized Persons – Long Term Care

Medicaid coverage may be granted to individuals in the following categories who need the level of care provided in a long term care facility (e.g., nursing home, hospital) and who need financial assistance to cover all or a portion of the cost of care:

- SSI recipient in a long term care facility,
- TCA-eligible person in a long term care facility,
- A child or aged, blind, or disabled adult who meets the Medicaid medically needy asset standard (e.g., $2,500 for a household of one person) and whose income is insufficient to cover entire cost of care in the long term care facility.

Home and Community-Based Services Waivers

Medicaid coverage may be granted under a Medicaid home and community-based services waiver to individuals who meet the waiver's specific requirements:

- Meet the targeting criteria for the specific waiver;
- Have income no more than 300% of the SSI benefit level for a household of one person;
- Have assets no more than $2,000; and
- Be certified as needing the institutional level of care covered under the specific waiver.

Program of All-Inclusive Care for the Elderly (PACE)

Medicaid coverage may be granted under Program of All-Inclusive Care for the Elderly (PACE) to individuals who meet the PACE program eligibility requirements:

- Must currently reside in the PACE service area in southeast Baltimore City and Baltimore County;
- Must be at least 55 years old;
- Must meet a PACE nursing facility level of care;
- Must have an approved PACE plan of care and receive all health and long-term care services exclusively from Hopkins Elder Plus (HEP) PACE and its providers; and
- Have income no more than 300% of the SSI benefit level for a household of one person and assets no more than $2,000

Medically Needy

To be determined eligible for Medicaid as "medically needy", the individual or family must be in one of the previously mentioned groups.

The individual's or household's income is used to determine if they meet the standards for medically needy.

- If your income is less than the Medicaid medically needy eligibility standard for your household size (e.g., $350 per month for a household of one person), you may be determined eligible.

- If your income exceeds the medically needy income standard, you may "spenddown" to qualify for Medicaid coverage during a six-month period. The difference between the amount of your income and the eligibility standard is called **excess income**. Under the spenddown process, your application will remain open until the end of the six-month period. If during that time you incur medical expenses, the amount of your medical bills can be deducted from your excess income. If you eliminate your excess amount within the six-month period, you may be determined eligible for Medicaid for the remainder of the six-month period.

- To qualify for Medicaid as "medically needy", your assets (i.e., resources) must be less than the cap for your household size (e.g., $2,500 for a household of one person). There is no spenddown process for assets. If a person or household is over-scale as of the first day of the month, the person or household is ineligible for the entire month. The individual or household will remain ineligible until the assets are reduced to below the medically needy cap through allowable means (such as daily living expenses). If the assets are transferred or disposed for less than full value, there may be a penalty period of ineligibility for Long Term Care or waiver applicants.

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

This program covers women for Medical Assistance services who have been screened through the Breast and Cervical Cancer Program (BCCP)(which has certain income limitations) and diagnosed with breast or cervical cancer. The following must be met:

- Be a woman between the age of 40 and 64 years old, who is a Maryland resident;
- Be uninsured, or have insurance that does not cover cancer treatment;
- Be in need of treatment; and
- Not be eligible or pending eligibility for Medicaid under a mandatory Medicaid categorically needy coverage group. (i.e. SSI)

There are no additional income and assets limitations, as long as the woman is screened through the BCCP program under DHMH Public Health Services program and meets other eligibility criteria (i.e. residency, citizenship, social security number).

To request an application or for additional questions, you may contact the **Breast and Cervical Cancer Coordinator** at your local health department.

Coverage for Medicare Premiums, Co-Payments, and/or Deductibles Only

This coverage is for persons who do not qualify for Medical Assistance, but who do qualify for Medicare. It provides assistance with Medicare costs. The assets standard is $4,000 for one person or $6,000 for a couple.

- Qualified Medicare Beneficiary (QMB):
  Medicaid pays the Medicare Premium (Part A and/or Part B), co-payments, and deductibles for Medicare covered services. To be eligible for QMB, an individual's income cannot exceed 100% of the Federal Poverty Level (FPL).

- Specified Low Income Medicare Beneficiary Group I and II (SLMB I or II):
  Medicaid pays for the Medicare Premium (Part B) only. To be eligible for SLMB I or II, an individual's income must be more than 100% FPL but less than 135 % of the FPL.

- Qualified Disabled Working Individuals (QDWI):
  Medicaid pays the Medicare Premium Part A (Hospital Insurance) for non-elderly employed persons with a disability who lost Social Security benefits due to employment and whose income is no more than 200% of the FPL.

Other Medical Care Programs

Maryland Children's Health Program (MCHP)

Uninsured children under age 19 are eligible for MCHP medical coverage if their family income is less than 200 percent of the Federal Poverty Level (FPL). In order to be eligible for benefits under this program, a child applicant may not be currently covered by or voluntarily dropped employer-sponsored group health plan or health insurance coverage within six (6) months before the date of application to the Local Health Department or Department of Social Services. Pregnant women qualify if their family income does not exceed 250 percent of the FPL. There is no asset test for MCHP.

MCHP eligibles receive the full range of Medicaid covered services and are enrolled in the Maryland Managed Health Care Program, *HealthChoice*.

Maryland Children's Health Program (MCHP) Premium

Uninsured children younger than 19 whose family income is at least 200 percent but no more than 300 percent of the Federal Poverty Level may be eligible for Maryland Children's Health

Program (MCHP) Premium. MCHP Premium assists families with paying health insurance costs for employer-sponsored insurance if the employer qualifies. If the employer's insurance plan does not qualify, the child (ren) will be enrolled in Maryland Managed Health Care Program, *HealthChoice.*

In order to be eligible for benefits under this program, a child applicant may not be currently covered by or voluntarily dropped employer-sponsored group health plan or health insurance coverage within six (6) months before the date of application to the Local Health Department or Department of Social Services.

In addition, a parent or guardian must be willing to pay a monthly family contribution. This contribution is per family, not per child.

Maryland Pharmacy Assistance Program (MPAP)

Persons who are not eligible for full Medicaid benefits may qualify for coverage of pharmacy benefits through the Maryland Pharmacy Assistance Program (MPAP). MPAP helps low-income individuals pay for the full range of pharmacy services covered under the Medical Assistance Program. Recipients pay a co-pay for each prescription and refill. To qualify for MPAP, a person must meet income and asset standards for the household size (e.g., income no more than $858 per month and assets no more than $3,750 for a household of one person).

Persons in the following Medical Care Programs that do not include pharmacy benefits may be eligible for MPAP:

- Transitional Emergency Medical and Housing Assistance (TEMHA), state-only benefits through the Department of Human Resources;
- Family Planning Program (FPP);
- Specified Low Income Medicare Beneficiary (SLMB); or
- Qualified Medicare Beneficiary (QMB) (who are automatically enrolled in MPAP without filing an application).

To receive an MPAP card you must complete the Maryland Pharmacy Assistance Program application form and mail it to:

Maryland Pharmacy Assistance Program
P.O. Box 386
Baltimore, MD 21203

You must provide written proof of all sources of income and assets. Please follow the directions carefully to avoid delays in receiving your MPAP card.

Applications take up to 30 days to process. Eligibility is for a 12-month period. You will be sent a renewal application 60 days before your current eligibility expires.

Applications are available at your Local Department of Social Services, the Area Agency on Aging, Local Health Department, and many hospitals and clinics. You may also request an application by calling 410-767-5394 or toll free 1-800-492-1974.

Family Planning Program

The Family Planning Program provides medical services related to family planning for women who lost their Medicaid coverage after they were covered for a pregnancy under the Maryland Children's Health Program (MCHP). The covered services include medical office visits, physical examinations, certain laboratory services, family planning supplies, reproductive education, counseling and referral, and tubal ligation. Coverage for family planning services continues for five years unless the individual:

- Becomes eligible for Medicaid or MCHP;
- No longer needs birth control due to permanent sterilization;
- No longer lives in Maryland; or
- Requests to be disenrolled.

Kidney Disease Program

The Kidney Disease Program (KDP) provides reimbursement for approved services required as a direct result of end-stage renal disease (ESRD). KDP eligibility is offered to permanent Maryland residents who are:

- Citizens of the United States or aliens lawfully admitted for permanent residence in Maryland;
- Diagnosed with ESRD; and
- Receiving home dialysis or treatment in a certified dialysis or transplant facility.

A patient is eligible to request financial assistance from the Kidney Disease Program when he/she begins chronic maintenance dialysis in a certified hospital or certified freestanding dialysis facility, or receives a renal transplant in a certified transplantation center.

Applications may be obtained from the affiliated dialysis or transplant facility or by calling the Kidney Disease Program at 410-767-5000. Completed applications and all required documentation should be submitted to the following address:

Kidney Disease Program of Maryland
201 West Preston Street
Room 314A
Baltimore, MD 21201

Based upon financial information provided by a patient at the time of certification/recertification, the Kidney Disease Program may assess an annual Program participation fee. This fee is based on 5% of the amount by which the family income exceeds 175% of poverty level and/or liquid assets exceed 200% of the poverty level guideline adjusted for the family size. The annual participation fee is due quarterly by specified payment dates. Annual recertification is required in order to maintain continuity of Kidney Disease Program coverage.

Covered services related to ESRD include:

- Chronic maintenance in-center and home dialysis,
- Renal transplantation,
- Approved inpatient and/or outpatient hospital care,
- Physician fees,
- Laboratory tests,
- Prescription and over-the-counter items in the Kidney Disease Program Reimbursable Drug List,
- Approved Medicare deductibles and coinsurance.