PART 2

BASIC ELIGIBILITY CRITERIA

SECTION 1: PROGRAM SCOPE

MaineCare is the name used by the State of Maine for programs that help individuals pay for health care costs. The Department's goal is to assist Maine residents in obtaining the benefits to which they are entitled. The programs are:

Medicaid (Title XIX of the Social Security Act). To be enrolled in Medicaid an individual must be both categorically and financially eligible. Each category has its own eligibility rules. Medicaid includes coverage for people living in the community or living in a long-term care facility.

Categorically Needy – This Medicaid category is made up of different mandatory and optional coverage groups covered within the state plan. An individual qualifies for Medicaid in this category if they meet the requirements of one of the Categorically Needy coverage groups.

Medically Needy – This Medicaid category provides coverage for individuals who meet the non-financial requirements of a Categorically Needy group but are financially ineligible. Coverage is gained by meeting a deductible.

Medicaid Waiver Groups – These are optional coverage groups approved by the Center for Medicare and Medicaid Services (CMS) under which an individual can become enrolled in Medicaid who might not otherwise be eligible. Examples are the Home and Community Based Waivers and the HIV Waiver.

Cub Care (Children's Health Insurance Program (CHIP), Title XXI of the Social Security Act) – This program provides coverage for children under the age of 19 within ~~higher~~ certain income ~~guidelines~~ limits~~and different eligibility rules than Medicaid~~. CHIP also provides coverage to pregnant individuals who are eligible for Medicaid but for their noncitizen status.

Medicare Savings Program (Buy-In) – This Medicaid category is a benefit for those who are entitled to Medicare Part A and who meet certain income criteria. Depending on income, the benefit is payment of Medicare Part B premium or payment of Medicare Part A and B premiums as well as coinsurance and deductibles.

The Office for Family Independence (OFI) also administers the following additional benefits under MaineCare:

Health Insurance Purchase Option (HIPO) – This program provides 18 months of extended health coverage to children under the age of 19 who are no longer eligible for MaineCare due to changes in income. (See 10-144 C.M.R. Ch. 335.)

Coverage for Noncitizens Under Age 21 – This state funded program provides coverage to individuals under the age of 21 who would be eligible for Medicaid but for their noncitizen status.

Low Cost Drugs for the Elderly and Disabled (DEL) – This state funded program assists elderly or disabled individuals with the cost of their medications. (See 10-144 C.M.R. Ch. 333.)

Maine Rx Plus – This state funded program assists Maine residents with the cost of their medications. Income guidelines are higher than under DEL and the benefit is less. (See 10-144 C.M.R. Ch. 334.)

State Supplement – This is a cash payment to SSI recipients, and individuals who would otherwise be eligible for SSI except for income or citizenship criteria. (See Part 11.)

Spousal Living Allowance – This is a cash payment to a spouse of a resident of a Residential Care Facility or Cost Reimbursed Boarding Home. The spouse must meet income and asset criteria. (See Part 12 Section 5.)

SECTION 2: COVERAGE GROUPS AND ASSISTANCE UNITS

To be eligible for MaineCare an individual must fall within a category. With the exception of individuals who qualify for Medicaid under a waiver or for the Medicare Savings Program, individuals must fall into one of the Categorically Needy/Medically Needy coverage groups. Each coverage group has specific eligibility criteria and individuals can meet the eligibility criteria of more than one coverage group at the same time.

Once the Department has determined that an individual meets the criteria of one or more coverage groups possible assistance units for each coverage group are identified.

Choosing a coverage group:

An assistance unit is an individual or group enrolled in or applying for MaineCare. The assistance unit also includes individuals who are not covered, or not applying for coverage, but whose income, assets, and/or needs are considered in determining eligibility.

Individuals are placed in the coverage group and assistance unit that is most beneficial to them. An individual can be included in more than one assistance unit at the same time to ensure that everyone who wants coverage gets coverage. When not everyone who wants coverage can be covered and a decision needs to be made as to which family members will be covered, the Department shall inform the individual of the coverage options and give them the opportunity to choose which coverage is preferred.

SECTION 3: CITIZENSHIP AND IDENTITY

MaineCare and Cub Care applicants must declare their United States citizenship or qualifying noncitizen status and have their status verified to receive MaineCare benefits. An individual who is not a citizen of the United States may be eligible for full MaineCare benefits, or they may be eligible for emergency services only.

Section 3.1 Verification of Citizenship and Identity

I. Unless exempted below in Paragraph II(A) through (F), all members of a household applying for Medicaid and Cub Care (CHIP) must verify citizenship and identity. The Department will attempt to verify citizenship or qualifying noncitizen status through electronic services before requiring verification from the applicant or member.

II. The requirement to verify U.S. citizenship and identity does not apply to:

A. Current recipients of Supplemental Security Income (SSI).

B. Current recipients of Social Security benefits, based on the individual’s disability.

C. Individuals entitled to or enrolled in Medicare.

D. Children who receive child welfare assistance under IV-B of the Social Security Act or foster care assistance under IV-E of the Social Security Act. This exemption is for the child only, not the family providing the care.

E. A newborn whose mother receives Medicaid at the time of birth.

F. Individuals while covered under Presumptive Eligibility.

G. Individuals whose citizenship or eligible noncitizen status has been verified by the Department and for whom no change in status has been reported to the Department.

III. Applicants and household members who declare United States citizenship or a qualifying noncitizen status, who are otherwise eligible and only pending for verification of citizenship or noncitizen status, will be granted a reasonable opportunity period of 90 days from the date of request for verification to provide documentation necessary to prove citizenship or qualifying noncitizen status. MaineCare or Cub Care coverage will be provided during the reasonable opportunity period, starting with the first day of the month of application.

A reasonable opportunity period is not provided if an individual does not declare U.S. citizenship or a qualifying noncitizen status.

The reasonable opportunity period is defined as follows:

A. It begins the date after the member receives notice informing them they need to provide documentation of citizenship or qualifying noncitizen status. The date the notice is received is 5 days after the date on the notice.

B. It ends on the earlier of the date the Department verified the individual's citizenship or immigration status or at the end of the 90-day period if verification of citizenship or satisfactory noncitizen status was not obtained.

The Department may extend the reasonable opportunity period if the individual is making a good faith effort to obtain any necessary documentation, or if the Department needs more time to complete the verification process.

If the applicant does not provide documentation necessary to verify citizenship or qualifying noncitizen status of the applicant and household members within 90 days, benefits for unverified household members will end. A reasonable opportunity period will not be provided on subsequent applications submitted by or on behalf of the applicant or household members.

IV. Failure to declare or prove citizenship or qualifying noncitizen status may result in ineligibility for Medicaid or Cub Care. Emergency Services may be provided to an applicant who does not declare or is unable to prove declared qualifying noncitizen status within the reasonable opportunity period.

If an individual within a household is not eligible due to inability to prove citizenship, identity or noncitizen status, the individual will still be counted as part of the household and that person's income and assets will be included in determining eligibility for the rest of the household.

Section 3.2 Citizenship and Identity Requirements

I. A United States citizen is:

A. An individual born in the United States or its territories, including Puerto Rico, the Virgin Islands, Guam, and the Northern Mariana Islands, except those born to a foreign diplomat, and who otherwise qualifies for U.S. citizenship under §301 *et seq*. of the Immigration and Nationality Act; [8 U.S.C. §§ 1401-1409].

B. An individual born of a parent who is a U.S. citizen or who otherwise qualifies for U.S. citizenship under §301 *et seq*. of the Immigration and Nationality Act; [8 U.S.C. §§ 1401-1409].

C. A naturalized citizen.

D. A national (both citizen and noncitizen national):

1. Citizen National. A citizen national is an individual who otherwise qualifies as a U.S. citizen under §301 *et seq*. of the Immigration and Nationality Act. [8 U.S.C. §§ 1401-1409].

2. Noncitizen National. A noncitizen national is an individual who was born in one of the outlying possessions of the United States, including America Samoa and Swain's Island, to a parent who is a noncitizen national.

II. Primary Verification of Citizenship and Identity

The following documents may be accepted as proof of both citizenship and identity because each contains a photograph of the individual named in the document, and the citizenship and identity of the individual have been established by either the U.S. or a state government. Primary verifications satisfy both citizenship and identity requirements:

A. U.S. passport, including U.S. passport card: a U.S. passport need not be currently valid to be accepted as evidence of U.S. citizenship, if it was originally issued without limitation. However, a passport that was issued with limitation and is not currently valid may be used as proof of identity only. U.S. passports issued after 1980 show only one person. However, spouses and children were sometimes included on one passport through 1980. The citizenship and identity of the included person can be established when one of these passports is presented.

B. Certificate of Naturalization (Department of Homeland Security form N-550 or N-570);

C. Certificate of U.S. Citizenship (Department of Homeland Security form N-560 or N-561); or

D. Tribal enrollment documents, evidencing membership or affiliation with a Federally recognized tribe.

III. Secondary Verifications of Citizenship

If primary verification from the list in Paragraph II of this section is unavailable, the person should provide satisfactory documentary verification from Paragraph VI of this section to establish identity, and satisfactory verification of citizenship from the list below:

A. A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam, the Virgin Islands of the U.S., American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986 (NMI local time)). The birth record document may be issued by the state, commonwealth, territory, or local jurisdiction. It must have been recorded before the person was 5 years of age. (A delayed birth record document that is amended after 5 years of age is considered fourth level evidence of citizenship. See section V, paragraph B.

B. If the document shows the individual was born in Puerto Rico, Guam, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. Collective naturalization occurred on the dates listed for each of the Territories. The following will establish U.S. citizenship for collectively naturalized individuals:

1. Puerto Rico

    a. evidence of birth in Puerto Rico and the person's statement that they were residing in the U.S., a U.S. possession, or Puerto Rico on January 13, 1941; or

    b. evidence that the person was a Puerto Rican citizen and the person's statement that they were residing in Puerto Rico on March 1, 2017 and that they did not take an oath of allegiance to Spain.

2. U.S. Virgin Islands

    a. evidence of birth in the U.S. Virgin Islands, and the person's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927; or

    b. the person's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on January 17, 2017 and residence in the U.S., a U.S. possession, or the U.S. Virgin Islands on February 25, 1927, and that the person did not make a declaration to maintain Danish citizenship; or

    c. evidence of birth in the U.S. Virgin Islands and the person's statement indicating residence in the U.S., a U.S. possession, or Territory or the Canal Zone on June 28, 1932.

3. Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands {TTPI}):

    a. evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. Territory or possession on November 3, 1986 (NMI local time) and the person's statement that they did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or

b. evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the person's statement that they did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or

c. evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that they did not owe allegiance to a foreign state on November 4, 1986 (NMI local time).

d. If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the person is not a U.S. citizen.

C. A Certification of Report of Birth (DS-1350)

The Department of State issues a DS-1350 to U.S. citizens in the U.S. who were born outside the U.S. and acquired U.S. citizenship at birth, based on the information shown on the FS-240. When the birth was recorded as a Consular Report of Birth (FS-240), certified copies of the Certification of Report of Birth Abroad (DS-1350) can be issued by the Department of State in Washington, D.C. The DS-1350 contains the same information as that on the current version of Consular Report of Birth FS-240. The DS-1350 is not issued outside the U.S.

D. A Report of Birth Abroad of a U.S. Citizen (Form FS-240)

The Department of State consular office prepares and issues this. A Consular Report of Birth can be prepared only at an American consular office overseas while the child is under the age of 18. Children born outside the U.S. to U.S. military personnel usually have one of these.

E. A Certification of Birth Issued by the Department of State (Form FS-545 or DS-1350)

Before November 1, 1990, Department of State consulates also issued Form FS-545 along with the prior version of the FS-240. In 1990, U.S. consulates ceased to issue Form FS-545. Treat an FS-545 the same as the DS-1350.

F. A U.S. Citizen I.D. Card

This form was issued as Form I-197 until the 1980s by INS. INS issued the I-179 from 1960 until 1973. It revised the form and renumbered it as Form I-197. INS issued the I-197 from 1973 until April 7, 1983. INS issued Form I-179 and I-197 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.

G. A Northern Mariana Identification Card (I-873)

The former Immigration and Naturalization Service (INS) issued the I-873 to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986. The card is no longer issued, but those previously issued are still valid.

H. An American Indian Card (I-872) issued by the Department of Homeland Security (DHS) with the classification code “KIC”

DHS issues this card to identify a member of the Texas Band of Kickapoos living near the U.S./Mexican border. A classification code of “KIC” and a statement on the back denote U.S. citizenship.

I. A final adoption decree showing the child's name and U.S. place of birth

In situations where an adoption is not finalized and the state in which the child was born will not release a birth certificate prior to final adoption, a statement from a state-approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.

J. Evidence of U.S. Civil Service employment before June 1, 1976

The document must show employment by the U.S. government before June 1, 1976. Individuals employed by the U.S. Civil Service prior to June 1, 1976 had to be U.S. citizens.

K. U.S. Military Record showing a U.S. place of birth

The document must show a U.S. place of birth (for example a DD-214 or similar official document showing a U.S. place of birth.)

L. A verification with the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) database. Inclusion in this database could prove citizenship through naturalization.

M. Evidence of meeting the automatic criteria for U.S. Citizenship outlined in the *Child Citizenship Act of 2000*.

N. Evidence of meeting the automatic criteria for U.S. citizenship under the provisions of the INA in effect on the person’s birthdate or adoption date, if the person’s birthdate or adoption date was prior to the February 27, 2001 enactment date of the *Child Citizenship Act of 2000* (citizenship laws are not retroactive, so the law applicable at the time the person was born or adopted applies, even if that law was subsequently repealed and replaced by a new section).

IV. Third-Level Verification of Citizenship

If verification from the lists in Paragraphs II and III of this section is unavailable and the person claims a U.S. place of birth, the person should provide satisfactory verification from Paragraph VI of this section to establish identity, and satisfactory verification of citizenship from the list below:

A. Extract of a hospital record on hospital letterhead, indicating a U.S. place of birth. The hospital record must have been established at the time of the person’s birth and created five years before the initial application date for Medicaid or Cub Care (For children under age 16, the document must have been created near the time of birth or five years before the date of application). A souvenir “birth certificate” issued by a hospital does not satisfy this requirement.

B. Life, health, or other insurance record showing a U.S. place of birth. The record must have been created at least five years before the initial application date for Medicaid or Cub Care.

C. Religious record recorded in the U.S. within three months of birth showing the birth occurred in the U.S. and showing either the date of the birth or the individual's age at the time the record was made. The record must be an official record recorded with the religious organization. (Entries in a family bible are not considered religious records.)

D. Early school record showing a U.S. place of birth. The school record must show the name of the child, the date of the admission to the school, the date of birth, a U.S. place of birth, and the name(s) and place(s) of the birth of the applicant's parents.

V. Fourth-Level Verification of Citizenship

If verification from the lists in Paragraphs II, III, and IV of this section is unavailable and the person claims a U.S. place of birth, the person should provide verification from Paragraph VI of this section to establish identity, and satisfactory documentary evidence of citizenship from the list below:

A. Federal or State census record showing U.S. citizenship or a U.S. place of birth. The census record must also show the applicant’s age.

Census records from 1900 through 1950 contain certain citizenship information. To secure this information, complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks portion “U.S. citizenship data requested”. Also add that the purpose is for Medicaid and Cub Care eligibility.

B. One of the following documents that show a U.S. place of birth and was created at least five years before the application for Medicaid and Cub Care:

1. Seneca Indian tribal census record;

2. Bureau of Indian Affairs tribal census records of the Navajo Indians;

3. U.S. State Vital Statistics official notification of birth registration;

4. A delayed U.S. public birth record that is recorded more than five years after the person's birth;

5. Statement signed by the physician or midwife who was in attendance at the time of birth; or

6. Bureau of Indian Affairs Roll of Alaska Natives.

C. Institutional admission papers from a nursing facility, skilled care facility or other institution, showing a U.S. place of birth, created at least five years before the initial application.

D. Medical (clinic, doctor, or hospital) record showing a U.S. place of birth. The record must have been created at least five years before the initial application date for Medicaid or Cub Care. (For children under age 16, the document must have been created near the time of birth or five years before the date of application.)

An immunization record alone is not considered a medical record for purposes of establishing U.S. citizenship.

E. Written Affidavits of Citizenship

F. Declarations should only be used in rare circumstances. If the documentation requirement needs to be met through affidavits, the following rules apply:

1. There must be at least two affidavits by two people who have personal knowledge of the event(s) establishing the individual's claim of citizenship (the two affidavits could be combined in a joint declaration).

2. At least one of the people making the affidavit cannot be related to the applicant or recipient. Neither of the two individuals can be the applicant or recipient.

3. In order for the affidavits to be acceptable, the people making them must be able to provide proof of their own citizenship and identity.

4. If the people making the affidavits have information that explains why documentary evidence establishing the individual's claim of citizenship does not exist or cannot be readily obtained, the declaration should contain this information as well.

5. The applicant or recipient or other knowledgeable person (guardian or representative) must also provide an affidavit explaining why the evidence does not exist or cannot be obtained.

6. The affidavits must be signed under penalty of perjury.

VI. Evidence of Identity

The following documents, even if expired, may be accepted as proof of identity and must be submitted when the person uses, as proof of citizenship, the documents listed in Paragraphs II through V of this section. (A separate document proving identity need not be submitted when the person submits primary evidence of citizenship and identity as outlined in Paragraph II of this section):

A. A driver's license issued by a U.S. state or territory. The license must either have a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color.

B. School identification card. The card must have a photograph of the individual.

C. U.S. military card or draft record.

D. Identification card issued by the federal, state, or local government. The card must have the same information that is required for driver's licenses.

E. Military dependent's identification card.

F. Native American tribal document.

G. U.S. Coast Guard Merchant Mariner card.

H. Certificate of Degree of Indian Blood, or another U.S. American Indian/Alaska Native Tribal document. The document must have a photograph or other personal identifying information relating to the individual.

A voter's registration card does not meet this requirement, as the Centers for Medicare and Medicaid Services (CMS) does not view this as a reliable form of identification.

I. In the absence of the documents described in Section 3.2(VI)(A) through (H) of this part, three or more corroborating documents such as marriage licenses, divorce decrees, high school and college diplomas from accredited institutions, including general education and high school equivalency diplomas, property deeds or titles, and employer ID cards can be used to verify the identity of an individual.

If the individual submitted fourth level verification of citizenship, Section 3.2(VI)(I) does not apply.

VII. Special Identity Rules for Children and Certain Individuals with Disabilities

An individual with a disability in a residential care or institutional facility may have their identity attested to by the facility director or administrator when the individual does not have or cannot get any document on the preceding lists. The affidavit is signed under the penalty of perjury but need not be notarized.

Children under age 16 may have their identity documented using one of the following if none of the documents in Paragraph VI are available:

A. School record including report card, daycare or nursery school record, verified by the Department with the issuing school.

B. Clinic, doctor or hospital record.

C. An affidavit of identity. An affidavit of identity is only acceptable if it is signed under penalty of perjury by a parent, guardian, or caretaker relative stating the date and place of the birth of the child and cannot be used if affidavits were used to establish citizenship.

Identity affidavits may be used for children under age 18 in limited circumstances, when the child is from an area where a school ID with picture is not provided or a driver's license with a picture is not available.

VIII. Documentary Evidence

Electronic data matching is the primary method of verifying citizenship and identity. If citizenship cannot be verified electronically, the applicant must provide documentary evidence of their citizenship as listed in Paragraph II through VII of this section.

A. All documents must be either originals or copies certified by the issuing agency.

B. Copies of citizenship and identification documents shall be maintained in the case record or electronic data base.

C. Individuals may submit documentary evidence without appearing in person at an OFI office. Documents may be tendered in person, by mail, or by a guardian or authorized

representative. Originals or certified copies presented by the applicant or recipient will be returned.

D. Presentation of documentary evidence of citizenship is a one-time activity; once a person's citizenship is documented and recorded in a state database, subsequent changes in eligibility should not require repeating the documentation of citizenship unless later evidence raises a question of the person's citizenship.

E. The requirement to provide documentary evidence is the responsibility of the applicant. If documentation is not presented at application, the individual will be given a reasonable opportunity to provide the documentation.

Section 3.3 Documentation and Verification for Noncitizens

An individual who is not a citizen or national of the United States must present alien registration documentation, other proof of immigration registration from the U.S. Citizenship and Immigration Services (USCIS), or other documents indicating the individual's qualifying noncitizen status. If the individual declares a satisfactory noncitizen status and documentation is not presented at application, the individual will be given a reasonable opportunity to provide the documentation. See Part 2, Section 3.1(III). Following the reasonable opportunity period, Temporary MaineCare coverage, as described in Section 12.3 of this part, will not be provided if the applicant cannot provide satisfactory documentation of noncitizen status.

The Systematic Alien Verification for Entitlements Program (SAVE) is the USCIS operative system for verification of noncitizen status for individuals applying for MaineCare. The noncitizen status of applicants who declare a qualifying noncitizen status must be verified through SAVE. If electronic verification indicates that additional documentation is required to verify attested noncitizen status, the Department will request further information from the individual. If an applicant disputes the USCIS response, they may submit additional documentation. The Department will submit additional documentation received by the Department to SAVE to reattempt electronic verification of attested status.

Section 3.4 MaineCare Coverage for Noncitizens

The *Personal Responsibility and Work Opportunity and Reconciliation Act of 1996* (PRWORA), P.L. 104-193, describes noncitizens as either qualified or non-qualified aliens. PRWORA further defines aliens who are eligible to receive either full benefit Medicaid or emergency services only, and qualified aliens who are subject to the five-year bar from Medicaid eligibility.

An individual must provide documentation from the United States Citizen and Immigration Services (USCIS) to prove their noncitizen status.

If an individual admits to being an undocumented noncitizen, this information will not be shared with USCIS. All information is held confidential in accordance with Part 1, Section 2.

I. Noncitizens Eligible for Full Benefits

Below is a listing of noncitizen groups who may be eligible for full benefits. See Section 3.4(II) of this part for a listing of noncitizen statuses that are only eligible for Emergency Services.

A. Veteran or Active Duty Personnel

1. Lawfully residing in U.S.; and

2. A veteran of the U.S. Armed Forces with an honorable discharge or on active duty (not training) in the U.S. Armed Forces; or

3. Lawfully residing in the U.S. and a spouse or unmarried child of the veteran described in Paragraph I(A)(1) and (2) of this section. "Unmarried child" means a child is or could be claimed as dependent on veteran's tax return and meets MaineCare requirements for a dependent child.

B. Legal Permanent Resident

1. Legal permanent resident status (LPR) granted under Immigration and Nationality Act (INA).

   i. EXCEPTION**:** Legal permanent residents are not eligible for full benefits if they have been in the U.S. less than five years. There is no five-year waiting period if any of the following conditions applies:

      a. The individual's date of entry to the U.S. is prior to August 22, 1996;

      b. The individual is a child under the age of 21;

      c. The individual is pregnant;

      d. Prior to adjustment to legal resident status regardless of the LPR status-granted date, the noncitizen's status was Refugee (C, below), Asylee (D, below), Person whose deportation was withheld (E, below), Amerasian immigrant (J, below), or Cuban or Haitian entrant (K, below). This noncitizen is eligible as a Refugee, Asylee, Deportee, Amerasian immigrant, or Cuban / Haitian entrant (per Medicaid State Plan).

C. Refugee

1. Refugee status granted under §207 of the INA

D. Asylee

1. Asylee status granted under §208 of the INA

E. Deportation Withheld

1. Deportee status granted under §243(h) of the INA as in effect prior to April 1, 1997; or §241(b)(3) of the INA, as amended

F. Parolee

1. Parolee status granted for at least a year under §212(d)(5) of the INA.

   i. EXCEPTION: Parolees are not eligible for full benefits if they have been in the U.S. less than five years. There is no five-year waiting period if any of the following conditions applies:

a. The individual's date of entry to the U.S. is prior to August 22, 1996;

b. The individual is a child under the age of 21;

c. The individual is pregnant.

G. Conditional Entrant

1. Conditional entrant status granted under §203(a)(7) of the INA in effect before April 1, 1980

i. EXCEPTION: Conditional entrants are not eligible for full benefits if they have been in the U.S. less than five years. There is no five-year waiting period if any of the following conditions applies:

a. The individual's date of entry to the U.S. is prior to August 22, 1996;

b. The individual is a child under the age of 21;

c The individual is pregnant.

H. Battered Noncitizen or Battered Noncitizen's Minor Child

1. While lawfully residing in the U.S. the noncitizen or the minor child was battered or subjected to extreme cruelty by a spouse, a parent, or a member of the spouse's or parent's family residing in the same household as the noncitizen; and

2. batterer(s) no longer lives in same household, and

3. The noncitizen or the minor child meets the conditions set forth in §431(c) of PRWORA as amended (Section 431(c) of PRWORA, as amended, is codified at 8 USC 1641(c)).

i. EXCEPTION**:** Battered Noncitizens are not eligible for full benefits if they have been in the U.S. less than five years. There is no five-year waiting period if one of the following conditions applies:

a. The individual's date of entry to the U.S. is prior to August 22, 1996;

b. The individual is a child under the age of 21;

c The individual is pregnant.

I. Trafficking Victim

1. Noncitizens certified as a trafficking victim (TV) under 107(b)(1) of the *TV Protection Act of 2000*, P.L. 106-386.

J. Amerasian

1. Admitted to the U.S. pursuant to §584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988

K. Cuban or Haitian Entrant

1. As defined in §501(e) of the *Refugee Education Assistance Act of 1980*

L. American Indian Born in Canada

1. The individual is at least one-half American Indian blood and provisions of §289 of the INA apply

M. Native American who is a Member of a Federally-Recognized Indian Tribe

1. Member of an Indian tribe under Section 4(e) of the *Indian Self-Determination and Education Assistance Act*

N. Iraqi Special Immigrant Eligibility Under Public Law 110-161 and 110-181, Section 1244

1. Has same status as refugee under 2009 Department of Defense Bill.

O. Afghani Special Immigrant Eligible Under Public Law 110-161

1. Has same status as refugee under 2009 Department of Defense Bill.

P. Compact of Free Association (COFA) Migrants

1. Effective December 27, 2020 individual citizens from the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

Q. Lawfully Residing Pregnant Women, and Children Under the Age of 21

1. Under the *Children's Health Insurance Program Reauthorization Act of 2009*, Section 214, lawfully residing pregnant women and children under the age of 21 include:

   i. A "Qualified alien" otherwise subject to the five-year waiting period per Section 403 of the *Personal Responsibility and Work Opportunity Reconciliation Act of 1996*;

   ii. A citizen of a Compact of Free Association State (i.e., Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau) who has been admitted to the U.S. as a non-immigrant and is permitted by the Department of Homeland Security to reside permanently or indefinitely in the U.S.;

   iii. An individual described in 8 C.F.R. § 103.12(a)(4) who does not have a permanent residence in the country of their nationality and is in a status that permits the individual to remain in the U.S. for an indefinite period of time, pending adjustment of status. These individuals include:

      a. An individual currently in temporary resident status as an Amnesty beneficiary pursuant to Section 210 or 245A of the *Immigration and Nationality Act* (INA);

      b. An individual currently under protected Status pursuant to Section 244 of the INA;

      c. A family Unity beneficiary pursuant to Section 301 of Public Law 101-649 as amended by, as well as pursuant to, Section 1504 of Public Law 106-554;

d. An individual currently under Deferred Enforced Departure pursuant to a decision made by the President; and

e. An individual who is the spouse or child of a U.S. citizen whose visa petition has been approved and who has a pending application for adjustment of status; and

iv. An individual in non-immigrant classifications under the INA who is remaining in the U.S. for an indefinite period, including the following as specified in Section 101(a)(15) of the INA:

a. A parent or child of an individual with special immigrant status under Section 101(a)(27) of the INA, as permitted under Section 101(a)(15)(N) of the INA;

b. A Fiancé of a citizen, as permitted under Section 101(a)(15)(K) of the INA;

c. A religious worker under Section 101(a)(15)(R);

d. An individual assisting the Department of Justice in a criminal investigation, as permitted under Section 101(a)(15)(S) of the INA;

e. A battered alien under Section 101(a)(15)(U) (see also Section 431 as amended by PRWORA); and

f. An individual with a petition pending for 3 years or more, as permitted under Section 101(a)(15)(V) of the INA.

II. Noncitizens Eligible for Emergency Services

A noncitizen who does not declare a qualified noncitizen status from Paragraph I of this section, or has no USCIS documents regarding their noncitizen status, or who is an ineligible noncitizen as defined in Subparagraph B below, or who is a qualified alien subject to the five-year waiting period for full Medicaid can get Medicaid or Cub Care (CHIP) Emergency Services only. Individuals must still meet financial requirements and be in a coverable group. These individuals must meet all basic eligibility requirements (including Maine residency) except for citizenship or noncitizen status and providing a Social Security number. If these individuals intend to remain in Maine at the time of application, they will be considered Maine residents.

MaineCare Emergency Services coverage is only available for the noncitizen groups listed below:

A. Undocumented Noncitizen

1. Non-qualified noncitizens who do not have USCIS documentation of their citizenship status.

2. EXCEPTION: Individuals under the age of 21 described in Part 3, Section 2.1(V) and pregnant individuals described in Part 3, Section 2.3 (III) may be eligible for full MaineCare benefits.

B. Ineligible Noncitizen

1. Non-qualified noncitizens legally admitted on a temporary basis or for a specific time period. The following are examples of individuals who are ineligible noncitizens:

Except for (x) below, these noncitizens should have one of the following types of INS documents: Form I-94, Arrival-Departure Record; Form I-185, Canadian Border Crossing Card; Form I-186, Mexican Border Crossing Card; Form SW-434, Mexican Border Visitor's Permit; Form I-95A, Crewman's Landing Permit; or Form I-184, Crewman's Landing Permit and Identification Card.

i. Foreign government representatives on official business and their families and employees;

ii. Visitors for business or pleasure, including exchange visitors;

iii. Aliens in travel status while traveling directly through the United States;

iv. Crewmen on shore leave;

v. Treaty traders and investors and their families;

vi. Foreign students;

vii. International organization personnel and their families and servants;

viii. Temporary workers, including agricultural contract workers;

ix. Members of foreign press, radio, film or other information media and their families

x. Parolee in the U.S. under Section 212(d)(5) for less than one year

2. EXCEPTION: Some ineligible noncitizens may be included for full coverage under CHIPRA 2009, Section 214. Lawfully residing pregnant individuals and children under age 21 may be eligible for full benefits—refer to Paragraph I(Q) of this section, “Noncitizens Eligible for Full Benefits.” The term “lawfully residing” includes nonqualified noncitizens who are in the U.S. lawfully.

C. Qualified Alien Subject to the Five-Year Waiting Period

1. Qualified aliens who enter the United States on or after August 22, 1996 are subject to a five-year waiting period for full Medicaid unless they are specifically exempt from this waiting period or otherwise included in the State Medicaid Plan.

2. As indicated in Section 3.4 (I), the following qualified aliens are not subject to the five-year waiting period:

i. Qualified Aliens who came to the United States before August 22, 1996

ii. Legal Permanent Residents whose prior qualified alien status was Refugee, Asylee, Person whose deportation was withheld, Amerasian immigrant, Haitian entrant, or Cuban entrant.

iii. Pregnant individuals

iv. Children under the age of 21

v. The following Qualified Aliens:

a. Veteran or Active Duty Personnel

b. Refugee

c. Asylee

d. Deportation Withheld

e. Trafficking Victims

f. Amerasians

g. Cuban and Haitian Entrants

h. American Indian born in Canada

i. Native Americans who are members of Federally-recognized Indian Tribes

j. Iraqi Special Immigrants

k. Afghani Special Immigrants

3. Immigrants who entered the United States prior to August 22, 1996 and did not remain "continuously present" in the U.S. until becoming a qualified alien on or after that date are also subject to the five-year waiting period. Any single absence of more than 30 consecutive days or a combined total absence of 90 days before obtaining qualified alien status interrupts "continuous presence."

4. The five-year waiting period begins on the date the immigrant obtains qualified alien status. Once the five-year waiting period expires, the qualified alien is eligible for full Medicaid benefits.

SECTION 4: RESIDENCY

Each individual must be a resident of Maine. A resident is an individual living in the State of Maine with the intent to remain indefinitely.

An individual who is in Maine temporarily (e.g., visitor, tourist, or student) is not a resident. The individual should apply to their actual state of residence for Medicaid.

If the individual is living in Maine and has entered the State with a job commitment or seeking a job (even if only a temporary job, e.g., migrant workers), the individual is a Maine resident.

When two or more states cannot resolve which state is the state of residence, the state where the individual is physically located is the state of residence for Medicaid purposes.

Eligibility cannot be denied or terminated because:

I. An individual has not resided in the State for a specified period;

II. The individual did not establish residence before entering a medical institution; or

III. An individual is temporarily or involuntarily absent from the State, provided the individual intends to return once the purpose of the absence has been accomplished, unless another state has determined the individual is a resident there.

IV. An individual does not have a fixed address (e.g., individual is homeless).

Eligible individuals who move out of Maine, intend to remain out of state, and are applying for Medicaid in that state, remain eligible until the other state determines eligibility.

Section 4.1: Children

For purposes of residency a child is any individual under the age of 21. A dependent child is a resident of the state where the parent/caretaker relative resides. An independent child is a resident of the state where they reside with an intent to remain indefinitely.

An individual under age 21 who is a full-time student in the State of Maine will not be considered a resident of Maine if each of the following conditions exist:

I. Neither of the individual's parents reside in the State of Maine;

II. The individual is claimed as a tax dependent by someone who resides in a state other than Maine; and

III. The individual is applying for coverage on their own behalf.

Section 4.2: Title IV-E of the Social Security Act

In any situation where a child is eligible for a Title IV-E payment (including the Federal Adoption Assistance Program) from another state, Medicaid determines the state in which the child is physically living as the state of residency (See Part 3, Section 3.). Children who are receiving services under the Interstate Compact for the Placement of Children (ICPC) and who are not receiving Title IV-E payments from another state are not considered residents of the State of Maine.

Section 4.3: Residents of Medical Institutions

I. If a state arranges for an individual to be placed in an institution located in another state, the state making the placement is the individual's state of residence, regardless of the individual's indicated intent or ability to indicate intent.

II. For any institutionalized individual who became incapable of indicating intent before age 21, the state of residence is that of the individual's parents, or legal guardian. If the parents reside in separate states and there is no appointed legal guardian, the state of residence is that of the parent applying for Medicaid on the individual's behalf.

III. For an institutionalized individual who became incapable of indicating intent on or after age 21, the state of residence is the state in which the individual was living when the individual became incapable of indicating intent.

IV. The state where the institution is located is the individual's state of residence unless that state determines that the individual is a resident of another state by applying the rules under Paragraph I or II of this section.

V. For any other institutionalized individual, age 21 or over, the state of residence is the state where the individual is living with the intention to remain for an indefinite period of time.

Section 4.4: SSI and State Supplement Recipients

An individual who is receiving SSI or State Supplemental payments is considered a resident of the state making the payment.

Section 4.5: Ability to Indicate Intent

An individual is considered incapable of indicating intent if:

I. The individual has an I.Q. of 49 or less, or has a mental age of seven or less based on tests acceptable to the Office of Aging and Disability Services (OADS);

II. The individual has been judged legally incompetent; or

III. Medical or other acceptable documentation supports a finding that the individual is incapable of indicating intent.

SECTION 5: SOCIAL SECURITY NUMBERS

All individuals applying for Medicaid coverage are required to have a Social Security number or proof of having applied for one, except:

I. Undocumented noncitizens;

II. Individuals with a religious exemption; or

III. A child who is born to a mother covered by Medicaid at the time of their birth. By the time the child turns one a Social Security number or proof of having applied for one, must be provided.

All individuals applying for Medicaid coverage are asked to provide their Social Security number at the time of application.

Except as noted in Paragraphs I-III of this section, an applicant seeking benefits is required to furnish the Department with a Social Security number. If the applicant has a Social Security number but is unable to provide it, the Department must contact the Social Security Administration to obtain the number.

The applicant is required to apply to the Social Security Administration for a Social Security number if they do not have one. The Department must assist the individual in obtaining verification necessary to apply for a Social Security number. This includes obtaining documents to prove date of birth, citizenship, or identity if these materials cannot be provided by the individual. The Department cannot pay any costs incurred in obtaining this information. The applicant or recipient must provide the Department with verification that the application for a Social Security number has been made. The Social Security number will be provided by the Social Security Administration.

For a child born to a mother not covered by Medicaid at the time of the child's birth, the Social Security number requirement must be met by the first day of the second month following the month in which the child's mother is discharged from the hospital.

Examples

1. A child is born on July 3. Mother leaves the hospital on July 6. Application for a Social Security number for the child must be completed by September 1.

2. A child is born on July 31. Mother leaves the hospital on August 2. Application for a Social Security number for the child must be completed by October 1.

MaineCare will not be withheld or terminated for lack of a Social Security number if an individual provides verification of application for a Social Security number for those requesting assistance. MaineCare will not be withheld or terminated while verification of the individual's Social Security number is being obtained from the Social Security Administration.

Section 5.1: Social Security Non-Compliance and Sanctions

For any individual who fails to provide, or apply, for a Social Security number as required, Medicaid and/or Cub Care must be denied or terminated.

When the Social Security number requirements for a dependent child are not met, the parent/caretaker relative as well as the child must be denied or terminated for Medicaid and/or Cub Care.

I. When an individual is not eligible for MaineCare due to non-compliance, the individual is counted in the assistance unit and the individual's income and assets (when applicable) are used to determine eligibility for other members within the assistance unit.

II. SSI-Related only - When a stepparent must be sanctioned for non-compliance, the stepparent's income will be considered as if the stepparent chose to be excluded from the assistance unit. The assets owned solely by the stepparent are not considered available to the assistance unit. The stepparent is not considered a member of the assistance unit when determining eligibility under the appropriate Federal Poverty Levels.

III. SSI-Related only - When a caretaker relative other than a parent or stepparent must be sanctioned for non-compliance, the caretaker relative's income and assets are considered in the same manner as a sanctioned parent's income and assets would be considered. However, such a sanctioned caretaker relative may choose to be excluded from the assistance unit.

An individual may request good cause for not providing a Social Security number. See Section 8 of this Part for specific information regarding good cause.

Section 5.2: Retroactive Coverage

If otherwise eligible, retroactive coverage will be granted if the Social Security number requirements are met during the application process. If the Social Security number requirements are not met, but at a later date the individual cooperates with these requirements, the retroactive coverage cannot be granted.

Examples

1. A parent refuses to apply for a Social Security number for a child. The parent and the child are denied coverage. One month later, the parent agrees to comply. The parent and child are eligible, effective the first day of the month in which the application for a Social Security number is made. Retroactive coverage cannot be granted.

2. A parent refuses to apply for a Social Security number. Coverage for the parent only must be denied. A year later, the person reapplies and gives a Social Security number proving application for the number was made six months previously. Eligibility may be authorized with up to three months' retroactive coverage because the applicant complied with the Social Security number requirements prior to the retroactive period.

Individuals must be informed that the Social Security number will be used to administer the MaineCare benefit, including eligibility decisions, and will be used for verification of information such as wages, unemployment benefits and bank accounts.

SECTION 6: ASSIGNMENT OF RIGHTS TO MEDICAL PAYMENTS

Certain individuals must assign their rights to payment for medical care from any third party to the Department of Health and Human Services and cooperate in obtaining these medical payments. This is done by a referral to the Third-Party Liability (TPL) Unit.

Section 6.1: Who Must Comply

I. Parents or caretaker relatives applying on behalf of themselves and their children;

II. Individuals age 18 or over who are applying on their own behalf; and

III. Individuals under age 18 who are applying on their own behalf who are married or in the military.

This provision does not apply to individuals who are pregnant, or those receiving only the Medicare Savings Program or one of the State funded benefits listed in Section 1of this part.

Section 6.2: Third-Party Liability Requirements

I. Assign rights to payment for medical care;

II. Cooperate with the TPL Unit in obtaining medical payments; or

III. Relinquish medical payments received directly from a third-party resource that were intended to cover services paid by Medicaid.

IV. Items for prospective, current, and retroactive periods that must be reported include:

A. Any court ordered responsibility to pay medical bills by a parent, unless it can be demonstrated that contact with the parent by the TPL Unit or Division of Support Enforcement and Recovery (DSER) could cause harm;

B. Medical insurance (except Medicare) covering the applicant or recipient. This includes private medical group insurance, TRICARE (formerly CHAMPUS), and supplemental policies such as companion plans from Blue Cross/Blue Shield, major medical, and indemnity insurance. Reporting is required whether the cost of premiums is paid by the individual, employer, or another party;

C. The portion of Worker's Compensation benefits for medical services for which the recipient is applying, receiving, or which terminated during the retroactive eligibility period; and

D. Information regarding settled or pending lawsuits involving personal injury.

Section 6.3: Noncompliance

I. Individuals who fail to comply with assignment of rights to medical payments are not eligible for Medicaid. In cases where Medicaid is open at the time of the failure to comply, Medicaid will be closed. When parents or caretaker relatives are applying on behalf of themselves and their children, the parent or other caretaker relative applying on behalf of the child under age 18 is not eligible. The child remains eligible.

II. When an individual is not eligible for Medicaid due to non-compliance, the individual is counted in the assistance unit size and the individual's income and assets (when applicable) are used to determine eligibility for the assistance unit.

III. SSI-Related Only – When a stepparent must be sanctioned, the stepparent's income will be considered as if the stepparent chose to be excluded from the assistance unit. The assets owned solely by the stepparent are not considered available to the assistance unit. The stepparent is not considered a member of the assistance unit when determining eligibility under the appropriate Federal Poverty Level.

IV. SSI-Related Only – When a caretaker relative other than a parent or stepparent must be sanctioned, the specified relative's income and assets are considered in the same manner as a sanctioned parent's income and assets are considered. However, such sanctioned caretaker relative may choose to be excluded from the unit.

An individual may request good cause for non-compliance with TPL. See Section 8 of this part for specific information regarding good cause.

SECTION 7: COOPERATION IN OBTAINING MEDICAL SUPPORT FROM THE NON-CUSTODIAL PARENT AND ESTABLISHING PATERNITY

Section 7.1: Who Must Comply

Certain individuals must cooperate in obtaining medical benefits from the non-custodial parent of a dependent child (See Part 3) and in establishing paternity. If the individual can show that good cause for not cooperating exists, no referral will be made.

These individuals are parents or caretaker relatives applying on behalf of themselves and their children unless the assistance unit is being covered under Transitional Medicaid.

This provision does not apply to individuals who are pregnant, individuals covered under Transitional Medicaid, individuals enrolled only in the Medicare Savings Program, Maine Rx, DEL, or HIPO. An individual who does not comply with this requirement is not eligible for Medicaid. It is the parent or other specified relative applying on behalf of the child under age 18 who is not eligible, not the child.

Section 7.2: Child Support Requirements

I. Identify and help locate those parents of a dependent child for whom Medicaid is requested.

II. Cooperation includes responding to requests for information from DSER and appearing as a witness at a judicial or other hearing or proceeding.

Section 7.3: Noncompliance

I. If an individual who is required to do so fails to comply with these provisions, Medicaid is denied or terminated.

II. When an individual is not eligible for Medicaid because they do not cooperate with DSER the individual is counted in the assistance unit and the individual's income and assets (when applicable) are used to determine eligibility for the assistance unit.

III. SSI-Related Only - When a stepparent must be sanctioned, the stepparent's income will be considered as if the stepparent chose to be excluded from the assistance unit. The assets owned solely by the stepparent are not considered available to the assistance unit. The stepparent is not considered a member of the assistance unit when determining eligibility under the appropriate Federal Poverty Level.

IV. SSI-Related Only - When a specified relative other than a parent or stepparent must be sanctioned, the specified relative's income and assets (when applicable) are considered in the same manner as a sanctioned parent's income and assets are considered. However, such a sanctioned caretaker relative may choose to be excluded from the assistance unit.

An individual may request good cause (See Section 8 of this part) for noncompliance with obtaining medical support and establishing paternity.

SECTION 8: GOOD CAUSE

I. Applicant/Participant Rights

A. Every Medicaid or Cub Care applicant or recipient may claim good cause for refusing to cooperate with TPL, medical support, or cooperating with the Department's establishment of medical support from the non-custodial parent. When the individual claims good cause, sanctions are not implemented unless it is finally determined that good cause does not exist.

B. Applicants receive an explanation of cooperation requirements, sanctions, and the right to claim good cause. The Department may attempt to establish paternity and collect medical support in cases where there is no risk to the individual or children.

C. If good cause is not granted, the individual is given the opportunity to withdraw from the benefit or provide additional information to substantiate the claim. If good cause is granted, no referral is made.

II. Acceptable Reasons for Good Cause

Good cause for not cooperating with TPL, medical support, or establishment of medical support from the non-custodial parent may be claimed by the individual if the individual can demonstrate that—

A. cooperation may reasonably be anticipated to result in physical or emotional harm to the child or physical or emotional harm to the caretaker relative which would hinder the ability to care for the child,

B. legal proceedings for adoption of the child are pending before a court or the individual has been working with a social agency to decide whether to relinquish the child for adoption, or

C. the child was conceived as the result of rape or incest.

III. Verification of Good Cause

Documents from court records, law enforcement agencies, medical sources, social service agencies and any other legal document may be used to substantiate rape, adoption and physical or emotional harm to the child or caretaker relative. If such documents are unavailable, information may be secured from other sources familiar with the claims of the individual. The Department should assist the individual in obtaining the required evidence, but no contact with collateral sources will be made without the individual's knowledge and consent.

If the individual thinks that attempts to establish paternity or collect support would pose a risk to the individual or children, the individual must provide evidence to substantiate the claim of good cause not to cooperate.

The Department may make contact with the absent parent or putative father only if it is essential to the claim for good cause. The Department shall not make contact until the applicant or recipient has the opportunity to—

A. present additional evidence or information which makes contact with the absent parent or putative father unnecessary;

B. withdraw the application for assistance, or have the case closed; and

C. have the good cause claim denied.

IV. Good Cause Determinations

A. The Department determines whether an applicant's request for good cause is approved or denied. This decision, and the reason for the decision, are documented by the Department and provided to the individual in writing.

B. If good cause is not granted and the individual continues to refuse to cooperate, sanctions are applied to the individual, and the TPL unit and DSER proceed to establish medical support from the non-custodial parent without the individual's cooperation.

SECTION 9: INDIVIDUALS RESIDING IN PUBLIC INSTITUTIONS

I. Medicaid coverage is authorized for inmates of state prisons, Mountain View Correctional Facility, Long Creek Youth Development Center, and local or county jails, if the individual meets financial and non-financial criteria applicable to non-inmates. Medicaid will only pay for any coverable in-patient service provided to the inmate while they are an in-patient in a hospital, nursing home, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or juvenile psychiatric facility.

II. Individuals admitted to a medical institution classified as an IMD (Institution for Mental Disease) for over 30 days. Examples of Institutions for Mental Disease are Spring Harbor, Acadia, Riverview Psychiatric Center, and the Dorothea Dix Psychiatric Center. The following applies:

A. If over age 20 and under age 65, these individuals are not Medicaid eligible until they are released, conditionally or unconditionally, or are on convalescent leave from the facility. Individuals may apply prior to discharge.

B. If under age 21 (through age 20) or age 65 or over, coverage is available for all Medicaid coverable services.

SECTION 10: APPLICATION FOR OTHER BENEFITS

Individuals must apply for other benefits to which they may be entitled. This includes applying for the benefit and providing the Department with necessary information to determine eligibility.

I. Other benefits include, but are not limited to, Social Security, Railroad Retirement, Veteran's Pension/ Compensation, Worker's Compensation, and Unemployment Insurance. This provision does not apply to SSI, State Supplement, TANF cash benefits and other Federal, State, local or private programs which make payments based on need.

II. Individuals who apply for Medicaid and DEL and who are eligible for Medicare Parts A, B and/or D must be enrolled in or apply for these programs and a Medicare Part D Prescription Drug Plan at the next available opportunity to do so.

III. Individuals who are enrolled in Medicaid and DEL and subsequently become eligible for Medicare Parts A, B and/or D must be enrolled in or apply for these programs and a Medicare Part D Prescription Drug Plan at the next available opportunity to do so.

IV. There is good cause for not enrolling in Medicare and/or Medicare Part D Prescription Drug Plan if:

A. The individual is not eligible for Medicaid and DEL to pay any premiums and cost sharing for Medicare Parts A and/or B as described in Part 8.

B. The individual is denied enrollment by Medicare or by a Medicare Prescription Drug Plan due to circumstances beyond their control,

C. The individual has prescription drug coverage which is determined by the insurer to be creditable coverage. Creditable coverage means that the coverage on the average is at least as good as the standard Medicare Prescription drug plan. or

D. Enrollment is not cost effective as determined by the Pharmacy Benefits Manager.

V. The Department will not require an individual:

A. To file for other benefits when applying for them would result in no additional benefit which affects the individual's eligibility.

B. To pursue a claim for other program benefits through the appeals process.

C. Who is not applying for or covered by Medicaid to pursue a claim for other program benefits, for example, an ineligible spouse, parent or child.

SECTION 11: APPLICATION PROCESS

I. An application is a signed request for MaineCare coverage made through one of the following methods:

A. a document approved by OFI as an application form;

B. the My Maine Connection website;

C. the Federally Facilitated Marketplace (FFM) (https://www.healthcare.gov/);

D. The State Based Marketplace (SBM) (https://CoverME.gov); or

E. the telephone or fax machine

II. The individual or someone acting on the individual's behalf may sign the application form. The applicant may choose anyone to help in completing the form.

III. The date of application is the date the signed application form is received in any OFI office, the FFM, or the SBM. For presumptive eligibility, the date the form is signed and dated by both the applicant and the designated person at specified provider sites is considered the date of application (See Part 9 Section 4(2)(C) and Part 18, Section 4).

IV. All signed applications are acknowledged in writing. A written decision of eligibility is sent to the applicant.

V. A denied application is valid for the month of application and the following month. If new or required information is received to re-evaluate eligibility before the last day of the month following the application month, a new application is not required.

VI. All applicants or re-applicants for MaineCare are given information in writing, or verbally if appropriate, about the following:

A. services covered under MaineCare,

B. conditions of eligibility,

C. the individual's rights, including the right to an Administrative Hearing,

D. responsibilities of recipients, including reporting changes within ten days (See Section 12.2 of this Part), and

E. the 45-day application processing standard (See Section 12.3.1 of this Part).

Section 11.1: Subsequent requests for eligibility

An individual does not need to complete a new application form if:

I. open MaineCare and requesting eligibility for new members orally or in writing. The application date for the new member is the date the request is made. Additional information may still be needed to determine eligibility.

II. open under one MaineCare program (for example Medicaid) and requesting coverage under another MaineCare program (for example Buy-in). In this situation the application date is the date that the request is made, either orally or in writing. Additional information may still be needed to determine eligibility.

III. open MaineCare and now requesting coverage in a facility or Home and Community Based Waiver services. Additional information may still be needed to determine eligibility.

IV. SSI recipients moving to a residential care facility where SSI benefits continue. Additional information may still be needed to determine eligibility.

SSI Individuals who move to a nursing facility need to complete an application. Community coverage is to be kept open while determining eligibility in the facility.

A reapplication is any signed application form received after the notice period (See Section 15 of this Part). This includes review forms returned after that period.

Section 11.2: Recipients of SSI or State Supplement

Individuals and couples who are aged, blind, or have disabilities, who are recipients of SSI or State Supplement are automatically covered as Categorically Needy unless they refuse to assign their rights to payments for medical care. A separate application for Medicaid (including coverage for any Home and Community Based Waiver program) is not needed for these groups.

SECTION 12: CLIENT AND DEPARTMENT RESPONSIBILITIES

Section 12.1: Verification of Eligibility Factors

The individual or the individual's authorized representative is responsible for verifying information for all persons in the household whose circumstances affect the eligibility determination. If this information is not provided and cannot be verified electronically by the Department, or electronic verification is inconsistent with the individual’s attestation, the Department will notify the individual or the authorized representative what items require resolution. If, following this notice, verifications are not received, the Department is not able to determine eligibility and a denial or closure notice will be issued. It is the responsibility of the Department to assist the individual in establishing eligibility for MaineCare.

Verification of information needed to determine eligibility must be requested initially from the individual. If information is requested from other sources (with the exception of public records) the individual must be informed. If collateral contacts are necessary to determine eligibility and the individual does not give consent, denial or closure must occur because the Department is unable to determine eligibility.

Section 12.2: Reporting Responsibilities

It is the responsibility of the individual to report changes of income, assets, household composition and any other change in circumstances which affect eligibility for MaineCare. Such change is to be reported within ten days from occurrence. For income purposes, "occurrence" will be considered the date the increased income was received. For all other purposes, "occurrence" will be considered the date the change took place. Applicants and recipients are informed of reporting responsibilities in the notice of eligibility.

Eligibility will be recalculated within 30 days of the receipt of new information which may affect the level of MaineCare coverage or cause ineligibility.

Section 12.3: Temporary Coverage

Temporary Coverage is medical coverage that is authorized because an application has not been processed, by no fault of the applicant or their representative, and an eligibility decision has not been

issued, within forty-five days of the application date. As described in Section 3.3 of this part, Temporary Coverage will not be granted following the 90-day reasonable opportunity period.

Section 12.3.1: 45-Day Processing Standard

The applicant must be sent a notice of eligibility no later than 45 days after the date of application. The 45-day processing standard is the result of the settlement of a court case, *Polk, et al. v. Longley*. The consent decree stated that all applications must be acted upon and a decision made as quickly as possible.

I. Temporary Coverage is authorized when:

A. a decision is not made within 45 days. The Department must authorize temporary coverage. This provides medical coverage from day 46 until a final decision is made on the application.

B. it is necessary to obtain medical reports from physicians, hospitals, or other medical sources and such medical information is not requested from all necessary sources within five days after the date of application. If the reports are not received within 15 days of the first request, a second request must be sent. The applicant is to be notified whenever a second request is made to inform the individual that the necessary medical reports have not been received.

II. Temporary Coverage is not authorized if there is documentation that the applicant or the applicant's source of medical information has not cooperated in obtaining information necessary to make a decision.

Documented non-cooperation by the applicant or the source of the applicant's medical information means that the case record must contain sufficient information to show that the applicant or the source of the applicant's medical information was requested to provide specific information or verification, or carry out particular activities necessary to establish eligibility and that the applicant or medical source failed or delayed in doing so within a reasonable period of time.

Section 12.3.2: Ten Day Processing Standard for Deductibles

The consent decree filed as a result of *Polk, et al. v. Longley* also mandates that the Department issue a medical card no later than ten days after the applicant furnishes adequate information about incurred medical expenses in order to meet the deductible. See Part 10, Section 6 for information about verification of medical costs.

If the person is not issued a medical card within ten days of submitting the information, temporary coverage is issued, effective on the 11th day unless there is documentation that the individual is not cooperating.

Section 12.3.3: Ending Temporary Coverage

If the individual is found to be eligible, Medicaid coverage will go back to the first month of eligibility. This could be a retroactive month, the month of application or the first day of eligibility.

If the applicant is found ineligible after temporary coverage has been issued, the applicant is sent a notice of denial. There is no advance notice of adverse action (See Section 15 of this Part). The applicant becomes ineligible upon the receipt of the denial notice (five days from the day the notice is mailed).

In no instance may the dates of temporary coverage be eliminated. The individual may request a hearing regarding the denial, but temporary coverage will not continue pending the hearing decision. If the decision of the Hearing Officer is to remand the case back to the regional office for a new decision, temporary coverage is reinstated back to the date that the coverage stopped.

No payment for medical services provided to the individual during the period when the applicant was eligible for temporary coverage is recoverable from the applicant.

SECTION 13: ELIGIBILITY PERIODS/REVIEWS

An individual's eligibility period is based on the month the application is received. Eligibility for the prospective period is determined for 12 months for all MaineCare programs except for Medically Needy and Maine Rx Plus. Eligibility for Medically Needy is determined for a six-month period. Eligibility for Maine Rx Plus is determined for a 24-month period.

The eligibility period begins on the first day of the application month unless temporary coverage is being given. (See "45-Day Processing Standard", Section 12.3.1 of this Part). In some instances, the individual is not eligible for coverage during the month of application but is eligible for the following month. In this situation, the length of the eligibility period remains the same (6, 12 or 24 months), depending on the type of coverage.

A review is a re-determination of eligibility. Reviews may be completed online through the My Maine Connection website or by using the review form provided by OFI. If the recipient is determined no longer eligible a timely and adequate notice of the adverse action must be sent (See Section 15 of this Part). Recipients are provided at least 30 days from the date of the renewal form to respond and provide any necessary information to determine ongoing eligibility. If the completed review form is not received by the Department by the end of the month in which it is due coverage will end.

If the completed review form and/or required verifications are submitted within 90 days after the date of termination, a new application for MaineCare coverage will not be required. If found eligible, the individual’s coverage will be reinstated back to the date of termination.

Section 13.1: Changes within the Eligibility Period

Changes reported by recipients during the eligibility period must be reviewed to determine the effect of the change on the individual’s eligibility.

If the new information results in a change in the level of coverage, timely and adequate notice of the change of level or termination of benefits must be provided (See Section 15 of this Part.).

Certain categorically eligible individuals have a continuous period of eligibility even if changes occur. These groups are:

I. **Newborns**

If the newborn's mother is receiving Medicaid (or is covered as part of the retroactive period) on the date the baby is born, the baby is eligible regardless of the income of the assistance unit. The mother must be fully covered by Medicaid on the day of the baby's birth. If mother meets the deductible amount on the day of the baby's birth and is partially responsible for any medical bills on that date, the newborn is not eligible in this group.

Coverage continues for one year without regard to changes in income or other household changes. Coverage under this category ends effective the last day of the month in which the child reaches age one.

II. **Children Under Age 19**

Any categorically eligible child is continuously eligible for full benefits for 12 months after eligibility is determined by application or review without regard to changes in income or composition of the assistance unit. This provision includes a child on newborn coverage as well as children found eligible for an SSI-Related coverage group even if the SSI or State Supplemental benefits or disability determination end prior to the next MaineCare review. It does not apply to those enrolled in Katie Beckett or those receiving coverage under Transitional MaineCare. The 12-month period begins with the month of application or review. Eligibility within the 12-month period will end:

A. at the end of the month the child turns 19;

B. if the child ceases to be a state resident; or

C. if mail addressed to the child or child's household is returned as undeliverable.

III. **Pregnant Individual**

A. Effective August 1, 2022, pregnant individuals who are found eligible for MaineCare under Part 3, Section 2.3(I) are continuously eligible for 12 months beyond the date the pregnancy ends.

B. Effective December 1, 2023, pregnant individuals who are found eligible for the Children's Health Insurance Program (CHIP), and enrolled in CHIP while pregnant, under Part 3, Section 2.3(III) are continuously eligible for 12 months beyond the date the pregnancy ends.

Section 13.2: Medically Needy Eligibility Periods

Medically Needy recipients have a six-month eligibility period. Most must meet a deductible to gain eligibility. The only time the six-month deductible period is shortened is in situations when:

I. The individual, age 20, will turn 21 in less than six months;

II. The individual dies;

III. The individual becomes eligible for categorical coverage including coverage in nursing care status; or

IV. The individual voluntarily withdraws from the program. If the individual voluntarily withdraws and reapplies, new deductible periods (both retroactive and prospective) are established based on the new application. Some months of the retroactive coverage period from the first application may not be included in the new retroactive period which is established with the reapplication.

Medically Needy coverage begins on the day of the month that the deductible is met. The individual may have some responsibility for bills for medical services incurred on that day. If there is no deductible or the deductible is met with uncovered medical expenses, coverage begins on the first day of the month of eligibility.

Once the date of eligibility is established, unless there is a change in income which changes the deductible amount, or the individual becomes ineligible for Medicaid, coverage continues to the end of the deductible period. These individuals are entitled to review and timely and adequate notice as described in Section 13 of this part.

Although individuals who are eligible for Medically Needy coverage are in a deductible for six months, if their income is stable and is between the Categorically Needy income levels and the Protected Income Level (PIL) – (See Chart 5), a complete review is necessary once every 12 months rather than once every six months.

Section 13.3: Changes within the Medically Needy Eligibility Period

Changes that impact eligibility are required to be reported and can result in a change in coverage or deductible amount. The Department shall review reported changes to determine the effect on the amount of the deductible or coverage. If the deductible amount or coverage changes, the recipient is provided timely and adequate notice of the change. (See Section 15 of this Part.)

Section 13.4: Retroactive Period

An applicant for Medicaid may receive retroactive coverage of up to three months prior to the application month. The exception to this rule is when the individual is only eligible for the Qualified Medicare Beneficiary (QMB) Buy-In group for the retroactive period.

I. Eligibility for retroactive coverage must be determined separately from prospective coverage. It is possible for an individual to be covered as Medically Needy during the retroactive period and Categorically Needy prospectively or vice versa.

II. The individual must meet basic eligibility requirements for any month during which coverage is received. For example, a person who turned age 65 in the month of application cannot be covered retroactively under an SSI – Related category unless SSI-Related disability criteria are met during the retroactive period. The individual does not have to be eligible in the month of application to be eligible for retroactive coverage.

The entire three-month period may be covered if the individual is eligible for all three months. Medicaid will not cover the third month prior to the application month without including the first and second months unless the individual is ineligible due to basic eligibility requirements or excess assets during the intervening months.

Examples

1. The individual applies in August and has medical expenses incurred in May. There are no medical expenses for June or July. The individual has a deductible of $300 per month.

To cover the expenses incurred in May, the deductible is $900 for three months, not $300 for one month. June and July could be covered with a deductible of $600, or only July could be covered with a deductible of $300. Coverage must be continuously retroactive from the application month.

2. The individual applies in March and incurred medical expenses in December, January and February. They met basic eligibility and asset requirements for December and February, but not January. Expenses incurred in the month of January cannot be covered by Medicaid as the individual was not eligible. The person's deductible for December and February are added together. Expenses incurred in January for which the individual is still responsible can be used as non-covered items toward meeting the deductible. (See Part 10.)

The individual who has a deductible period may withdraw from the program and reapply for retroactive coverage. If an individual voluntarily withdraws, a new prospective period begins with the month of the new application and retroactive eligibility can be determined for up to three months prior to the month of the new application. In determining eligibility for the retroactive period, income received during that period is used.

Individuals who are determined to be eligible for SSI benefits and who indicate on their SSI application that they have medical expenses for the three months prior to their application for SSI do not need to make a separate application for retroactive Medicaid coverage.

If the individual meets the non-financial criteria and the Department has enough information in the case record about the individual's financial situation to determine eligibility for the retroactive period, the individual will be sent a notice of eligibility for MaineCare. If there is not enough information in the case record, or no case record exists, the Department will contact the individual in writing to request verification of specific information.

Individuals who are determined to be eligible for SSI and who indicate on the application for SSI that they do not have medical expenses for the three months prior to their application for SSI will be sent a notice of denial for the three-month period.

SECTION 14: CLOSINGS AND DENIALS

Before MaineCare coverage is ended or denied, it must be determined that the individual is not eligible under any coverage group. This includes:

I. Doing a disability determination when there is information that the individual can potentially meet the disability criteria;

II. Determining medical and financial eligibility for a Waiver, Nursing Home Care, or Katie Beckett coverage groups when there is information that the individual can potentially meet these criteria;

III. Determining continuing coverage when SSI/State Supplement cash benefits end;

IV. Determining eligibility under Cub Care and Maine Rx.

When individuals lose eligibility for SSI and/or State Supplement payments and a review for continued MaineCare is needed, existing information in the case record is used to determine continuing eligibility for MaineCare. If there is insufficient information in the case record to determine eligibility or a disability determination is necessary, coverage must be continued until ineligibility is determined. If a review form is

necessary, it must be sent to the individual within ten days of the date SSI and/or State Supplement coverage has ended.

SECTION 15: NOTICES

Individuals are notified in writing as soon as eligibility is determined. If some of the individuals applying for MaineCare are eligible and some are not, the notice must specify who is and who is not eligible and the reasons for each individual's ineligibility.

I. Individuals whose eligibility begins after the month of application must be sent a denial notice for the month(s) of ineligibility.

II. All individuals who apply for Medicaid must be notified of their eligibility for retroactive coverage. Such notification must indicate the months of eligibility or ineligibility.

III. When an individual is determined to be ineligible, the notification contains—

   A. a statement that the application has been denied,

   B. the specific reason(s) for the denial,

   C. the manual citations which support the decisions, and

   D. an explanation of the individual's right to request a hearing.

IV. In situations when the intended action is to discontinue eligibility or to reduce services, timely and adequate notice must be given to the recipient.

   A. “Timely” means that the notice must be mailed 15 days before the intended change would be effective (ten days for notice plus five days for mail).

   Timely actions resulting from computer matching mass changes, such as annual cost of living adjustments to Social Security and other Federal benefit updates require an advance notice of 30 days prior to the effective date of the action.

   The only situations in which the timely notice guarantee is not required are as follows:

   1. Factual information is received confirming the death of the recipient;

   2. A written statement that assistance is no longer wanted is received by the Department. Such statement must be signed by the recipient or the recipient's representative;

   3. The recipient has been committed to a public institution (See Section 9 of this Part.);

   4. The recipient's cost of care changes (See Part 12, Sections 4.3.4; Part 13, Section 6; and Part 14, Section 6.2.);

   5. The recipient's whereabouts are unknown and Departmental mail directed to the recipient has been returned;

   6. An applicant for MaineCare has been covered temporarily due to the Department's failure to determine eligibility within the 45-day time limit and is later found to be ineligible; or

7. Documentation is obtained that the individual is currently receiving Medicaid in another state.

B. "Adequate" means a written notice which includes a statement of—

1. the action the Department intends to take;

2. the reasons for the intended action;

3. the regulations supporting such action;

4. an explanation of the rights to request a hearing; and

5. a statement explaining that if a hearing is requested within the notice period, the intended action will not become effective until after a hearing Decision is rendered.

SECTION 16: UNFUNDED CHECKS

An unfunded or bounced check is considered non-payment of a premium. Upon notice from State Treasury that a check has bounced, the household will be sent a notice of non-payment including the amount now due. If no payment is received within 30 days of the first notice, a second notice is sent. If no payment is received, the penalty will take effect the month following the month in which the second notice is sent, if the client has received 15 days advance notice.

Example

The family is sent a second notice of non-payment on May 10. No payment is received within fifteen days. The penalty starts June 1. If the notice was not sent until May 30, the penalty would take effect July 1.

The penalty is a period of time that the client cannot get coverage under the option for which there is a non-payment. The duration of the penalty period depends on the coverage option involved.

For Working Disabled, coverage cannot continue after the end of the current or last enrollment period unless the unpaid premiums are paid.

For the Special Benefit Waiver, coverage cannot continue after the end of the current period unless all outstanding premiums are paid.

For Katie Beckett, coverage cannot continue after the end of the current three-month premium period unless all outstanding premiums are paid.

Note: A family's three-month enrollment period cannot be ended to impose this penalty.

PART 3

ELIGIBILITY GROUPS REQUIREMENTS

SECTION 1: DEFINITIONS

DEPENDENT CHILD: A dependent child means a child who is under the age of 18 or is age 18 and a full-time student in secondary school (or equivalent vocational or technical training), if before attaining age 19 the child may reasonably be expected to complete such school or training.

FEDERAL POVERTY LEVEL (FPL): A measure of income issued annually by the Department of Health and Human Services (HHS) that is used to determine financial eligibility for programs and benefits. The poverty guidelines are updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. § 9902(2).

SECTION 2: ELIGIBILITY GROUPS FOR WHICH MAGI-BASED METHODOLOGY APPLIES

To be eligible for MaineCare in a coverage group for which MAGI-based methodology applies, an individual must:

I. Be a covered individual;

II. Have an eligibility group;

III. Meet basic eligibility criteria in this Part and in Parts 2 and 17; and

IV. Meet income criteria.

To get Medicaid coverage under an eligibility group for which MAGI-based methodology applies, an individual must meet the criteria of at least one of the groups listed in Sections 2.1-2.4 of this part. An individual may meet the criteria of more than one group at the same time in which case they should be enrolled with the group which is the easiest way for them to get the best coverage.

Section 2.1: Children

I. Newborns

A. If the newborn’s mother is receiving Medicaid (or is covered as part of the retroactive period) on the date the baby is born, the baby is eligible regardless of the income of the household. The mother must be fully covered by Medicaid on the day of the baby’s birth. If the mother meets the deductible amount on the day of the baby's birth and is partially responsible for any medical bills on that date, the newborn is not eligible in this group.

B. Coverage continues for one year. This means that the baby is eligible without regard to changes in income or composition of the household.

II. Other Children Under Age One

A. Individuals under the age of one who are living with a parent/caretaker relative or with unrelated others are eligible if they meet other applicable eligibility rules in Parts 2 and 17.

B. Countable income must be equal to or less than the applicable standard in Part 4. Types of countable income are described in Part 17.

C. If the individual is receiving inpatient hospital services on the last day of the month in which the first birthday occurs, eligibility continues until the last day of the in-patient stay if the individual continues to meet all other eligibility criteria.

III. Age 1 through Age 18

A. Individuals age one up to and including age 18 (under age 19) who are living with a parent/caretaker relative or who are living alone or with unrelated others are eligible for Medicaid if they meet other applicable eligibility rules in Part 2 and Part 17.

B. Countable income must be equal to or less than the applicable income standard in Part 4. Types of countable income are described in Part 17.

C. If the individual is receiving inpatient hospital services on the last day of the month in which the 19th birthday occurs, eligibility continues until the last day of the inpatient stay if the individual continues to meet all other eligibility criteria.

IV. Age 19 or 20

A. Individuals age 19 or 20 who are living with parent/caretaker relatives or who are living alone or with unrelated others are eligible for Medicaid if they meet other applicable eligibility rules in Part 2 and Part 17.

B. Countable income must be equal to or less than the applicable income standard in Part 4. Types of countable income are described in Part 17.

C. If the individual is receiving inpatient hospital services on the last day of the month in which the 21st birthday occurs, eligibility continues until the last day of the in-patient stay if the individual continues to meet all other eligibility criteria.

V. Coverage for Noncitizens Under Age 21

A. Effective July 1, 2022, individuals under the age of 21 who would be eligible for assistance under federal Medicaid programs listed in Section 2.1(I)-(IV) of this part, but for their noncitizen status are eligible for state-funded medical assistance through MaineCare.

B. Countable income must be equal to or less than the applicable income standard in Part 4. Types of countable income are described in Part 17.

C. If the individual is receiving inpatient hospital services on the last day of the month in which the 21st birthday occurs, eligibility continues until the last day of the in-patient stay if the individual continues to meet all other eligibility criteria.

Section 2.2: Parent/Caretaker Relative

I. A parent/caretaker relative means a relative of a dependent child by blood, adoption or marriage with whom the child is living, who assumes primary responsibility for the child's care (as may, but is not required to, be indicated by claiming the child as a tax dependent for Federal income tax purposes), and who is one of the following:

A. The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece;

B. The spouse of such parent or relative, even after the marriage is terminated by death or divorce; or

C. Another relative of the child based on blood (including those of half-blood), adoption or marriage.

Countable income must be equal to or less than the applicable income standard in Part 4. Types of countable income are described in Part 17.

II. Maintenance of a Home

The parent/caretaker relative must be living with a dependent child for whom a home is maintained. The child must be under age 18 or is age 18 and expects to graduate from high school prior to their 19th birthday.

The specified relative does not need to have legal custody as a result of court action in order to be considered to be maintaining a home for the child.

If the child lives part of the time with each parent, the parent with whom the child resides over 50% of the time must apply for the child.

If the child lives 50% of the time with each parent, either parent can apply for the child but not both.

If a child is living with their biological parents but the parents are not married, all three have a coverable group and are potentially eligible. Each parent has a coverable group because each is residing with their child under age 18 (or 18 and expects to graduate from high school by age 19).

If the only child is between the ages of 19 and 21, (or is age 18 and does not expect to graduate from high school prior to the 19th birthday), the parent or caretaker relative cannot receive Medicaid coverage unless the parent or caretaker relative is eligible in another category (e.g., a pregnant ~~woman~~ individual or meets SSI disability criteria).

Examples

A. The household consists of a single mother and her 18 year old son. In June, the boy graduates from high school. The boy may remain eligible for Medicaid since he has a coverable group (under age 21).

The mother is no longer eligible. She has no coverable group since she is not living with a dependent child covered by Medicaid and she is not pregnant and does not meet SSI disability criteria.

B. The household consists of a mother, father, and their 19 year old daughter. The daughter may be eligible, depending on the income requirements of her coverage group; however, the parents cannot be covered as a parent/caretaker relative.

C. The household consists of a mother, father, and 17 year old girl who is a sophomore in high school. On the child's 18th birthday, the parents' coverage is due to end. Discussion with the family prior to terminating the parents' coverage reveals that the mother has a condition which might meet disability criteria under the SSI program. Coverage for the girl continues. Coverage for the father is terminated. Coverage for the mother continues pending a decision from the Medical Review Team on her disability. If she does not meet criteria for SSI - Related disability (see Part 6, Section 4.3), her coverage must also end.

D. An individual, age 20, is the caretaker relative of their 18-year-old sister. When the sister graduates from high school, both can continue to receive Medicaid as both are still eligible for coverage through the infants and children under age 21 group.

III. Physical Separation

A child may be separated physically from their parent/caretaker relative and still be considered to be living with the parent/caretaker relative, provided that the parent/caretaker relative retains full and exclusive responsibility for the supervision and guidance of the child, offers a home during vacations, and any other delegation of authority to another by the parent/caretaker relative is temporary, voluntary, and revocable.

When separation occurs, it is expected that the child or parent/caretaker relative will return home at the completion of the reason for the separation. The following criteria meet the conditions for when a child or parent/caretaker relative is away from the home.

A. To secure education when high school facilities are not maintained in the place of residence or if existing facilities do not meet the child's educational or social needs. In this later instance, the assessment of needs and the development of a responsible plan must be made through the parent/caretaker relative and a recognized social service agency.

B. To secure planned supervised therapy in a private, organized treatment center such as Sweetser Home, when such is necessitated by special needs of a physical or emotional nature.

C. To attend Governor Baxter State School for the Deaf, provided that adequate resource for therapy cannot be found or developed in the child's own community.

D. To attend a vocational or technical school or college or university.

E. For care for a terminal illness which probably will prohibit eventual return to the home, although if possible, the individual would do so.

F. For other purposes, such as visiting or moving to another community and similar situations where temporary separation occurs. In such situations, the separation may not exceed four months, unless the individual can demonstrate that there is a good reason and that the separation will end as soon as possible.

IV. Reunification

MaineCare coverage may continue for parents/caretaker relatives who would otherwise lose eligibility due to a change in household size when their child is removed from the home by Child Protective Services pursuant to state law. Eligibility will continue until the parent is either:

A. No longer participating in the rehabilitation and reunification plan as required by the plan; or

B. Until the parental rights have been terminated.

If the parent/caretaker is no longer eligible for reasons other than the change in household composition (e.g., an income increase, failure to renew, etc.) MaineCare eligibility may end.

Section 2.3: Pregnant Individuals

I. Pregnant individual means an individual during pregnancy and the post-partum period, which begins on the date the pregnancy ends, and extends for 12 months beyond the month in which the pregnancy ends.

Pregnant individuals whose countable income is equal to or below the applicable income standard in Part 4 are eligible. The household size is increased by one (or by two if the individual is expecting twins). Cooperation with Third Party Liability (TPL) and Division of Support Enforcement and Recovery (DSER) is not a factor in determining eligibility.

Retroactive coverage may be granted for up to three months if the individual was pregnant and financially eligible.

If an individual is eligible as a pregnant individual in the month of application, or the retroactive period, or due to a change in ongoing eligibility, they continue to be eligible for 12 months beyond the month in which the pregnancy ends.

Only the pregnant individual is eligible under this coverage group. Other family members must be in another coverable group.

If the individual is receiving inpatient hospital services on the last day of the month in which coverage as a pregnant individual occurs, eligibility continues until the last day of the in-patient stay if the individual continues to meet all other eligibility criteria in Part 2 and Part 17.

II. Presumptive Eligibility for Pregnant Individuals

A pregnant individual is eligible to receive ambulatory prenatal care beginning on the day that a qualified Medicaid provider determines that the pregnant individual's household's countable MAGI-based income is less than the applicable income standard in Part 4. This coverage is called "presumptive eligibility".

The qualified Medicaid provider will use a presumptive eligibility application to establish the MAGI household size and income for the presumptive determination. The Medicaid provider must contact the Department within five working days after the date the presumptive determination is made to report the name, date of birth, and Social Security number of each individual determined eligible under the presumptive eligibility standards.

Once the Medicaid provider has made a presumptive determination, the individual is eligible through the last day of the month following the month in which a presumptive determination is made. If the individual applies for Medicaid during this presumptive eligibility period, presumptive eligibility ends the day that the Medicaid application is granted or denied. Presumptive eligibility can only be determined once per pregnancy.

Example

A pregnant individual is determined presumptively eligible by the Medicaid provider on September 14. They receive coverage under presumptive eligibility through October 31. On October 31 they file an application for Medicaid. Because they applied for Medicaid within the presumptive eligibility period, the individual continues to be presumptively eligible through the day the application is granted or denied.

The Department is required to provide appropriate notices based on the standard Medicaid application, but is not required to send any notice regarding the discontinuance of the presumptive eligibility period. The individual has no appeal rights for the discontinuance of presumptive eligibility.

It is the responsibility of the Medicaid provider to:

A. provide the applicant with an approved standard MaineCare application form;

B. notify OFI of the presumptive eligibility determination within five working days from the date the determination was made;

C. notify the applicant (in writing and orally if appropriate) that if the applicant does not file a standard MaineCare application with OFI before the last day of the following month, presumptive eligibility coverage will end on that last day;

D. notify the applicant (in writing and orally if appropriate) that if the applicant files a standard MaineCare application with OFI before the last day of the following month, presumptive eligibility coverage will continue until an eligibility determination is made on the application that was filed.

III. Coverage for Pregnant Individuals ~~for the Health of Unborn Children During Pregnancy~~From Conception to End of Pregnancy and 12 Months Postpartum

Effective July 1, 2022, prenatal care and pregnancy related services are available through the Children's Health Insurance Program (CHIP) to pregnant individuals who are eligible for Medicaid but for noncitizen status. Effective December 1, 2023, ~~Eligibility~~ if an individual is eligible as a pregnant individual, and enrolled in CHIP while pregnant, eligibility from conception to end of pregnancy extends 12 months beyond the month in which the pregnancy ends, regardless of any subsequent changes in household income.~~when the pregnancy ends. Postpartum coverage is limited to the end of the month in which the pregnancy ends or a period necessary to allow for adequate and timely notice. See Part 2, Section 15(IV).~~

To be covered in this category the parent of the unborn child must be:

A. Pregnant

B. A resident of the State of Maine

C. Otherwise eligible for federally funded coverage but for citizenship.

D. Uninsured. Applicants are considered to be uninsured if they do not have credible health insurance that provides coverage of prenatal care services.

E. Countable income is equal to or less than ~~the applicable income standard for Cub Care in Part 5, Section 6~~208% FPL. Types of countable income are described in Part 17.

Section 2.4: Expansion Adults

Eligibility for this group must meet the qualifications below.

Expansion Adults means an individual between the ages of 19 and 64 who meets the following qualifications:

I. Is not pregnant;

II. Is not entitled to or enrolled for Medicare benefits Part A or Part B; and

III. Is not otherwise eligible for and enrolled in mandatory MaineCare coverage.

For parents and other caretaker relatives living with a dependent child under age 21 who meet the requirements in (I) through (III) of this section and either have income above 100% FPL or don't meet the requirements for a parent/caretaker under Section 2.2 of this part, the child must receive benefits

under Medicaid, CHIP, or otherwise be enrolled in minimum essential coverage as defined in 42 C.F.R. § 435.4 to be eligible as an expansion adult.

SECTION 3: OTHER NON-MAGI ELIGIBILITY GROUPS

Other special coverage groups refers to various special groupings created by federal and/or state legislation. Specifically, IV-E Eligible and State Adoption Assistance:

I. Move-In from Out of State

An individual under the age of 21, who is receiving Title IV-E funds from another state or is covered by a State Adoption Agreement from another state and moves to Maine, is eligible for Medicaid. The income and assets of the child and parents are not considered to determine eligibility for this child.

There must be an assignment of rights to medical support and the Department must be provided with a Social Security number for the child.

There are three groups of children who fall into this category:

A. Children whose medical and financial circumstances qualify them for federal IV-E adoption assistance;

B. Children whose medical and financial circumstances qualify them for federal IV-E foster care assistance; and

C. Children whose medical and financial circumstances qualify them for state adoption assistance.

The foster or adoptive parents in Maine are provided with a written explanation of their status by the state of origin which usually serves as verification of their status.

II. Maine Residents

The following children are eligible for Medicaid:

A. Foster children;

B. Children named in a Federal (IV-E) or Maine State Adoption Assistance Agreement;

C. Children who are placed in Permanency Guardianship by the State of Maine, as defined in 22 M.R.S. § 4038-C.

III. Former Foster Care Children

An individual is eligible to enroll in Medicaid if they:

A. Are under age 26;

B. Are not enrolled in another mandatory Medicaid coverage under 42 C.F.R. §§ 435.110 through 435.118 or 42 C.F.R. §§ 435.120 through 435.145; and

C. Effective January 1, 2023 were in foster care in any state in the United States and were enrolled in Medicaid at age 18. Prior to January 1, 2023 only individuals in foster care in the State of Maine were eligible under this coverage group.

The income and assets of the individual (or anyone else in their household) are not considered to determine eligibility for the individual.

SECTION 4: TRANSITIONAL MAINECARE

Transitional MaineCare (TM) is MaineCare coverage that is available to families who become ineligible for MAGI-based coverage due to increased earnings or hours of employment of the parent or caretaker relative (as defined by Section 2.2 in this Part), or because of receipt of or increase in alimony.

Section 4.1: General Requirements

Section 4.1.1: Covered Individuals

TM is available to individuals who were eligible for MAGI-based MaineCare coverage in either the Children Under 18, or the Parent/Caretaker groups (except Expansion Adults with income above 100% FPL).

TM households are determined on an individual basis using MAGI household composition rules. Some individuals may be granted TM while others may continue in MAGI coverage groups.

Membership in a TM household includes those individuals whose needs and income were included in determining eligibility for the MAGI coverage group at the time of closing.

The following individuals may also be added to a TM household:

I. a parent/caretaker relative who returns home whose needs and income would be considered in determining coverage under MAGI, and whose earnings/alimony, either alone or added to other income of the household, result in the loss of MAGI coverage;

II. a child or parent/caretaker relative who moves into the home after TM has started;

III. a child who is born after TM has started; or

IV. a pregnant ~~woman~~ individual who was included in a MAGI household and loses coverage after the end of ~~her~~ the pregnancy, if ~~her~~ the individual's spouse and/or dependent children are receiving TM.

Section 4.1.2: Conditions of Eligibility

At least one member must have been eligible for and receiving coverage under an eligibility group for which MAGI-based methodology applies in one of the three months immediately preceding ineligibility. Retroactive coverage under an eligibility group for which MAGI-based methodology applies will be counted for this purpose even if there is only one month of retroactive coverage and no current eligibility under an eligibility group for which MAGI-based methodology applies.

Example

A family applies in July and requests retroactive coverage for one month. The family is covered under an eligibility group for which MAGI-based methodology applies for June (the retroactive month) and is ineligible for coverage in July due to increased earnings. TM eligibility exists starting in July.

An individual is not eligible for TM if:

I. The State makes a finding that, at any time during the last 6 months the individual was ineligible for Medicaid because of fraud; or

II. Information is received which indicates the household was incorrectly determined eligible for MAGI-based coverage.

Individuals receiving TM must continue to assign their rights to payment for medical care from any third party (See Part 2, Section 6). The custodial parent is not required to cooperate in obtaining medical support or payments from the non-custodial parent.

Section 4.2: Eligibility for Transitional Medicaid: Individuals Who Become Ineligible for Coverage under MAGI-Based Coverage Due to Increased Earnings

Section 4.2.1: Computation of Transition Period

Individuals who lose eligibility in a coverage group for which MAGI-based methodology applies due to the earnings of a parent/caretaker relative may remain eligible for Medicaid for up to 12 months. The scope of services will be the same as those provided to those eligible under an eligibility group for which MAGI-based methodology applies.

The 12-month count begins the month after the individual would have becomes ineligible for MAGI coverage, . which may not necessarily be the effective month of the loss of coverage under an eligibility group for which MAGI-based methodology applies.

Example:

A family reports an increase in the parent's earnings on April 5. The parent is now ineligible in April. The first month for TM is April, the first month of ineligibility, and not May., which would be the effective month for the closing under an eligibility group for which MAGI-based methodology applies.

Section 4.2.2: Termination of TM

TM will be closed with timely and adequate notice when:

I. A child no longer resides within the household. The TM household must include a child who resides in the household. This child must be under the age of 18 or between the ages of 18 and 19, and a student regularly attending a secondary school on a full-time basis (or in the equivalent level of vocational or technical training at the high school level) and reasonably expected to complete the program prior to their 19th birthday.

II. The parent/caretaker relative is no longer employed. Note: good cause reasons will be requested for lack of employment and established by the Department. Some reasons for good cause for lack of employment include but are not limited to:

   A. dismissal/termination by the employer;

   B. illness of employed individual;

   C. care of other ill family members who are residing within the household;

   D. loss of transportation;

   E. harassment;

   F. risk to health and safety;

   G. loss of child care if there is not any other adequate replacement; or

   H. other reasons which indicate the action was not deliberate or willful.

III. The household moves out of state or the recipient’s whereabouts are unknown and Departmental mail has been returned.

IV. The member becomes eligible in another comparable MaineCare category.

A determination of whether the individual is potentially eligible for any other MaineCare categories must be made prior to the termination of Transitional Medicaid.

In situations when the intended Department action is to terminate coverage, timely and adequate notice must be given to the recipient as described in Part 2, Section 15.

Section 4.2.3: Client Reporting Responsibilities

The family must report when a child no longer resides within its household or when there are any other changes in the family composition. All changes must be reported within the time frames outlined in Part 2, Section 12.2.

Section 4.2.4: Department Notice Requirements

At the time of the closing under MAGI-Based rules, a determination must be made for the individual's eligibility for Transitional Medicaid and a notice must be sent informing the individual of the following:

I. The individual's eligibility for the extension and a medical card which lists all eligible members; and

II. The conditions under which the initial extension may be terminated.

A review is due in the 12th month. It is used to determine continuing eligibility for MaineCare coverage when TM ends.

Section 4.3: Eligibility for Transitional Medicaid: Individuals Who Become Ineligible for MAGI-Based Coverage Due to Increased Alimony

Transitional Medicaid coverage for persons with increased alimony is limited to 4 months; it continues irrespective of other changes in household income or composition.

Coverage under a MAGI-based eligibility group must have been closed solely because of an increase in the amount of alimony being received by an individual in the household.

The individual must have been eligible under a MAGI-based eligibility group for three of the six months prior to the month they are determined ineligible.

The four-month count for extended Medicaid begins with the first month after the individual became ineligible for MAGI coverage. of ineligibility even if the closing under MAGI-based methodology is later.

Example

A client reports in May that their alimony has increased and now the countable income exceeds program standards. The four-month extension begins in MayJune, even though the MAGI-based coverage cannot be closed for May.

At the end of the four-month period, the individual's coverage is to be reviewed for potential future coverage. If eligibility does not exist, coverage is to be ended following timely and adequate notice procedures (Part 2 Section 15).

PART 8

MEDICARE SAVINGS PROGRAM [BUY-IN])

SECTION 1: PROGRAM SCOPE

The Medicare Savings Program (MSP), also known as the Buy-In, provides qualified Medicare eligible individuals with Medicaid coverage that pays for their Medicare premiums. The Department also provides additional benefits for Qualified Medicare Beneficiaries (QMB), which are detailed below.

The Social Security Administration (SSA) enrolls SSI recipients for the Buy-In of Medicare Part B premiums. If the individual needs assistance with payment of Medicare Part A premiums, DHHS enrolls the individual in Qualified Medicare Beneficiaries (QMB). See Section 4.1 of this Part.

SECTION 2: BASIC ELIGIBILITY REQUIREMENTS

Individuals may be eligible for Buy-In if they meet the criteria of one of the groups listed in Section 4 of this Part. If not open for or applying for MaineCare, these individuals need to file an application for Buy-In with the Department.

Individuals must meet the basic eligibility requirements for SSI - Related MaineCare described in Part 6, except for individuals who have been diagnosed with end stage renal disease (ESRD). Individuals with an ESRD diagnosis do not need to meet the age or disability requirements.

SECTION 3: FINANCIAL ELIGIBILITY REQUIREMENTS

SSI - Related Categorically Needy MaineCare budgeting rules are used to determine Buy-In eligibility.

Buy-In is a separate benefit within Medicaid. As a result, one spouse of an eligible couple can choose to be an ineligible spouse to give Medicaid eligibility to the other, and at the same time the couple will both be considered for Buy-In eligibility.

Example

Mr. and Mrs. Mazure apply for MaineCare. Both have Medicare. Mr. Mazure has Social Security income of $920. Mrs. Mazure has Social Security income of $600. Using SSI - Related Categorically Needy budgeting for an eligible couple, both are eligible for Buy-In but over income for Medicaid. Mrs. Mazure has to see a specialist, and Mr. Mazure does not. Mr. Mazure can choose to be counted as an ineligible spouse for MaineCare. We then use the exclusions to deeming found in Part 7, Section 2.2.2, resulting in Mrs. Mazure being eligible for Medicaid, and both of them being eligible for Buy-In.

There is usually a delay between the time an individual is eligible for the Buy-In and the time the Buy-In premium payment begins. During this time, the individual continues to have premiums deducted from their Social Security benefits (See Appendix A).

Section 3.1: Individual Who Opted Out of Medicare

Individuals who are not automatically enrolled in Medicare Part A or B, are not entitled to premium-free Medicare Part A (such as those individuals over age 65 but who did not pay enough Medicare taxes), or who opt out of Medicare Part A and/or B coverage when it is first offered, are considered entitled to enroll in Medicare. These individuals are eligible to apply for Buy-In. The Department will start their coverage without waiting for open enrollment. The Medicare Part A and/or B start date will be the effective date of the Buy-in.

SECTION 4: COVERAGE TIERS

Section 4.1: Qualified Medicare Beneficiary (QMB)

I. Eligibility Requirements for QMB

A Qualified Medicare Beneficiary is an individual who:

A. is entitled to Medicare Part A or voluntarily enrolled in Medicare Part A;

B. has income equal to or less than 150% of FPL; and

C. may have assets. Effective January 1, 2024, there is no asset test. ~~has liquid assets of no more than $50,000 for an individual or $75,000 for a couple. “Liquid Assets” are defined in Part 16.~~

II. Description of QMB Benefits

A. Medicaid pays the cost of Medicare Part A and/or B premiums, as well as satisfying Medicare Part A and B deductibles and coinsurances (See Appendix A).

B. An individual may be eligible for QMB and Medicaid at the same time.

C. Coverage begins the month after the month in which an eligibility decision is made that the individual is eligible as a QMB. There is no three-month retroactive period.

Section 4.2: Specified Low Income Medicare Beneficiary (SLMB)

I. Eligibility Requirements for SLMB

A Specified Low Income Medicare Beneficiary is an individual who:

A. is entitled to Medicare Part A or is voluntarily enrolled in Medicare Part A;

B. has income over 150% of the Federal Poverty Level (FPL) and equal to or less than 170% of FPL; and

C. may have assets. Effective January 1, 2024, there is no asset testhas liquid assets of no more than $50,000 for an individual or $75,000 for a couple. "Liquid Assets" are defined in Part 16.

II. Description of SLMB Benefits

A. Medicaid pays the cost of Medicare Part B premium (see Appendix A).

B. An individual may be eligible for SLMB and Medicaid at the same time; and

C. coverage begins the month of application, retroactive to three months (but not prior to 1/1/93).

Section 4.3: Qualifying Individual (QI)

I. Eligibility Requirements for QI

A Qualifying Individual is an individual who:

A. is entitled to Medicare Part A or is voluntarily enrolled in Medicare Part A;

B. has income more than 170% of the Federal Poverty Level (FPL) but less than 185% FPL; and

C. may have assets. Eeffective January 1, 2024, there is no asset testhas liquid assets of no more than $50,000 for an individual or $75,000 for a couple. "Liquid Assets" are defined in Part 16.

II. Description of QI Benefits

A. Medicaid pays the cost of the Medicare Part B premium.

B. The individual cannot receive Medicaid coverage and this benefit at the same time; and

C. coverage begins the month of application up to three months retroactive but no earlier than 1/1/98.

Section 4.4: Qualified Disabled and Working Individual (QDWI)

I. Eligibility Requirements for QDWI

A Qualified Disabled and Working Individual is one who:

A. is entitled to Medicare Part A;

B. is not eligible for Medicaid;

C. has lost entitlement to Social Security disability benefits due to excess income from wages;

D. has countable income equal to or less than 200% of the FPL; and

E. has countable assets less than or equal to $4000.

II. Description of QDWI Benefits

A. Medicaid pays the cost of the Medicare Part A Premium.

B. Coverage begins the month of application, up to three months retroactive.