TO BE RESCINDED

5101:1-38-01 **Medicaid and covered families and children medicaid: the determination and redetermination of eligibility.**

(A) All calculations of time periods used in the determination and redetermination of eligibility shall be computed as follows:

(1) When counting the number of days in a specified time period, the initial day is excluded from the computation and the last day is included.

(2) When the last day of the time period falls on a Saturday, Sunday, or legal holiday, the time period shall end on the next working day.

(3) This method shall be used in calculating all time periods, unless working days are specified.

(B) After the face-to-face interview, when applicable as delineated in Chapters 5101:1-2 and/or 5101:1-38 of the Administrative Code, or review of an application for assistance that does not require a face-to-face interview, and after the CDHS has requested the verification and information required to establish the assistance group's eligibility for assistance, the CDHS shall contact the assistance group (AG) if the requested items are not received. The follow-up contact shall be in writing and shall be mailed or personally delivered no more than twenty days from the date of the application, except as noted in paragraph (D) of this rule. The written contact letter shall advise that the CDHS has not received the required information/verification and that, if the information/verification is not received within ten days, the CDHS shall deny the application for medicaid.

(C) This written follow-up shall include a clear statement that the CDHS will assist in obtaining the required information/verification if the request for assistance is received on or prior to the given deadline. This notice does not replace the need to mail or otherwise personally deliver an ODHS 7334 "Notice of Denial of Your Application" or the CRIS-E equivalent.

(D) Cases that involve pregnant women are to be considered priority cases and follow-up contact must be completed within ten days of the application date. The written contact shall advise that the CDHS has not received the required information/verification and that, if the information/verification is not received by the CDHS within twenty days, the CDHS shall deny the application.

(E) Failure to cooperate in the application process and/or with the verification requirements shall result in a denial of medicaid. Failure occurs:

(1) When the information/verification is not provided after the CDHS has properply advised the AG what information/verification is needed to determine eligibility and provided no request for assistance in obtaining information/verification was received by the CDHS; or

(2) When the CDHS is not given necessary information to assist in obtaining the verification needed to determine eligibility.

(F) The CDHS is responsible for determining eligibility for all medicaid programs.

(1) The CDHS is responsible for documenting and recording the determination of eligibility, and subsequently informing the AG of the eligibility decision.

(2) A determination of eligibility shall be made as soon as possible after the application requirements are complete.

(a) The determination of eligibility, including the gathering of any verifications, shall be completed as rapidly as possible within thirty calendar days (forty-five days if a disability determination is required) from the date of application.

(b) No more than forty-five days may elapse between the date of application and an ODHS 4074 "Notice of Approval of Your Application for Assistance" (or CRIS-E equivalent), an ODHS 7334 "Notice of Denial of Your Application for Assistance" (or the CRIS-E equivalent) or an ODHS 7332 "Notice of Denial of Your Application for Medicaid in Cases Involving Community Spouses." However, when a medicaid application is pending a disability or blindness determination, the application may pend up to ninety days before the appropriate notice is mailed.

(c) The CDHS must not use the time standards as a waiting period before determining eligibility.

(d) The CDHS must not use the time standards as a reason for denying eligibility because it has not determined eligibility within the time standards.

(3) The determination of eligibility shall proceed concurrently with the determination of blindness or disability and shall be completed within forty-five calendar days.

(4) The specific forty-five day or ninety-day limit may be exceeded in situations where completion of the determination of eligibility is delayed because of circumstances beyond the control of the CDHS. The following circumstances are considered beyond the control of the CDHS:

(a) Failure, with good cause, to secure necessary verifications.

(b) Failure or delay on the part of an examining physician to provide all needed information.

(c) When there is an administrative or other emergency beyond the CDHS' control.

The reasons for delay must be documented in the assistance group's case record.

(G) Mandatory application processing forms.

(1) In addition to the mandatory application processing forms delineated in Chapters 5101:1-2 and 5101:1-38 of the Administrative Code, all CDHS are required to use the following state formats and forms for processing applications:

(a) For all medicaid applications except healthy start, expedited medicaid, and, effective July 1, 2000, low income families medicaid (LIF), the ODHS 7104 "Application/Reapplication Verification Request" and the ODHS 7105 "Application/Reapplication Request Checklist."

(b) For healthy start/expedited medicaid and LIF, the ODHS 7220 "Application/Reapplication Verification Request Checklist for Healthy Start/Expedited Medicaid and LIF."

(c) ODHS format for "Application Follow-up Letter" for all medicaid applicants other than healthy start/expedited medicaid and LIF.

(d) The ODHS 7227 "Application Follow-Up Letter for Healthy Start/Expedited Medicaid and LIF."

(2) Upon approval of medicaid, the following individuals must be referred to the local special supplement nutrition program for women, infants and children (WIC) agency:

(a) Pregnant women;

(b) Postpartum women during the six months after termination of pregnancy;

(c) Women up to one year postpartum who are breast-feeding their infants; or

(d) Children below the age of five.

(3) A copy of the ODHS 7216, CPA, is the method used to refer these individuals to WIC. Individuals currently on the WIC program need not be referred.

(4) Upon approval of medicaid, each recipient must be given an ODHS 7114 "Medicare Supplement Insurance Policies (MEDIGAP)" notice that explains that medicaid recipients may suspend their MEDIGAP policy(ies) for up to twenty-four months.

(5) Upon approval of low income families medicaid (LIF) or OWF medicaid, the assistance group must be given a copy of the ODHS 7115 "Transitional Medicaid and Child Care" notice.

(H) The reapplication process is a periodic review and confirmation that the assistance group continues to meet all of the eligibility requirements of the program of assistance under which benefits are being issued. The following principles relate to medicaid, covered families and children medicaid (including healthy start), and Ohio's residential state supplement program (RSS). The reapplication process includes:

(1) Providing the materials described in Chapters 5101:1-2 and/or 5101:1-38 of the Administrative Code. The application form is not normally mailed with the materials unless the assistance group is not required to complete a face-to-face interview.

(a) A CAF is only issued if it is determined that the recipient or the recipient's authorized representative cannot participate in the face-to-face interactive interview.

(b) A combined programs application (CPA) is issued for assistance groups that are in receipt of healthy start or LIF only.

(c) An application for help with medicare expenses (ODHS 7103) is issued

for assistance groups that are in receipt of only QMB, SLMB, QI-1, QI-2 or QWDI.

(2) Conducting a face-to-face interview, if required. A face-to-face interview is not required for individuals in receipt of QMB, SLMB, QI-1, QI-2, QWDI, or healthy start. Effective July 1, 2000, a face-to-face interview will no longer be required for LIF.

(3) For assistance groups who are not required to complete a face-to-face interview, the CDHS, when issuing the application, must include in the application packet the deadline for returning the application.

(4) Informing the assistance group of its required involvement and cooperation in the reapplication process.

(5) Providing an interpreter at no charge to assistance groups with limited English proficiency.

(6) Reviewing basic eligibility factors and explaining rights, reporting responsibilities, healthchek, social services, and food stamps as appropriate. For those assistance groups who are not required to participate in a face-to-face interview the information is to be included in the reapplication packet that is issued to the AG.

(7) Obtaining verification of information when required pursuant to the rules in Chapter 5101:1-2 or 5101:1-38 of the Administrative Code which is new, has changed, or is subject to change.

(8) Completing the reapplication in a timely manner.

(9) Updating all county and state files upon completion of the reapplication process.

(I) The role of the CDHS in the reapplication process:

(1) The CDHS is responsible for the determination of continued eligibility for medicaid.

(2) When the reapplication is to be completed with a CRIS-E interactive interview, the CDHS shall initiate the reapplication process by sending all materials delineated in Chapter 5101:1-2 or 5101:1-38 of the Administrative Code, excluding the application form.

(3) When the CDHS becomes aware during the interactive interview that a new category of assistance or an additional category of assistance is needed or is requested, the CDHS shall require that an APPL or CPA be completed.

(4) The CDHS shall initiate any necessary actions when information has been received indicating any changes in the AG's circumstances which may affect their continued eligibility for medicaid. The change may also include a referral to WIC as described in paragraph (G)(2) of this rule.

(J) The role of the assistance group in the reapplication process:

(1) The AG is responsible for cooperating in the reapplication process.

(2) The AG is also responsible for answering all relevant questions during the face-to-face interview, if a face-to-face interview is required, and providing the necessary verifications to establish continued eligibility.

(3) Recipients of healthy start/expedited medicaid, QMB, SLMB, QI-1, QI-2 or QWDI medicaid are not required to participate in a face-to-face interview for these categories only. Effective July 1, 2000, recipients of LIF will no longer be required to participate in a face-to-face interview. They are required to provide the necessary verifications to establish continued eligibility.

(4) When the AG is not able to obtain requested information and requests assistance from the CDHS, the CDHS shall provide assistance in obtaining the information.

(5) Failure to cooperate occurs when verification, which was properly requested, is not provided and when the CDHS is not given necessary information to assist in obtaining the verification needed to determine whether eligibility for assistance continues.

(6) For AGs that are required to participate in a face-to-face interview, failure to appear for a scheduled reapplication appointment also constitutes failure to cooperate in the reapplication process. Failure to cooperate in the reapplication process and/or with the verification requirements shall result in termination of medicaid as continued eligibility cannot be determined.

(K) A reapplication of eligibility is required every twelve months for medicaid for the aged, blind, and disabled, QMB, SLMB, RSS, and, effective July 1, 2000, healthy start. Reapplications are required every six months for covered families and

children medicaid with the following exceptions and considerations:

(1) Eligibility for QI-1 and QI-2 is time-limited (I.E., eligibility expires at the end of each calendar year.). A reapplication must be completed prior to the end of the calendar year.

(2) A reapplication is not required for AGs who are in receipt of transitional medicaid benefits. A reapplication or pre-termination review (PTR), whichever is appropriate, is required to be completed prior to terminating transitional medicaid benefits.

(3) A reapplication is not required for newborns if the newborn is eligible for medicaid in accordance with rule 5101:1-40-022 of the Administrative Code. A reapplication is to be scheduled at the end of the one year period of deemed eligibility.

(4) A pregnant woman in receipt of medicaid shall remain eligible for medical coverage throughout her pregnancy and the sixty day post-partum period without being required to complete a reapplication. Reference rule 5101:1-40-08 of the Administrative Code for additional information.

(5) Effective July 1, 2000, healthy start assistance groups whose countable income is over one hundred and fifty per cent but less than or equal to two hundred per cent of the federal poverty level, are eligible for twelve continuous months of coverage without requiring a reapplication and regardless of changes that may occur within the assistance group. Reference rule 5101:1-40-08 of the Administrative Code for additional information.

(6) In multiple assistance cases, the reapplication date for continued medicaid eligibility is based on the intervals as required in paragraphs (K)(1) to (K)(5) of this rule and may not be the same as the reapplication date for other assistance programs.

(7) Based upon a reasonable belief that circumstances have changed that may affect eligibility, a CDHS may complete a reapplication or PTR in accordance with rule 5101:1-38-011 of the Administrative Code at any time other than the next regularly scheduled reapplication date. The CDHS must document in the case record the reason(s) for requiring a reapplication at any time other than the six month or twelve month intervals as stated above.

(8) Inability to complete the reapplication of eligibility or a PTR within the prescribed length of time shall not interfere with the prompt issuance of the

medicaid health card or be the basis for terminating assistance unless the assistance group fails to cooperate with the reapplication or PTR.

(L) The face-to-face interview requirement must be completed at least once in any twelve-month period or more frequently if required by the CDHS for all programs except QMB, SLMB, QI-1, QI-2, QWDI, healthy start/expedited medicaid and LIF. This requirement may be met by any one of those individuals allowed to complete the face-to-face requirement for applications as provided in Chapter 5101:1-2 or 5101:1-38 of the Administrative Code.

(1) In limited and unusual situations, the CDHS may experience a temporary delay in completing a reapplication because the face-to-face interview cannot be conducted. The CDHS may complete the reapplication without conducting the face-to-face interview if continued eligibility can be determined without an interview. Only in extenuating circumstances may a reapplication be completed without conducting the face-to-face interview at least once in every twelve months. The case record must contain sufficient documentation to support the CDHS' decision not to conduct an interview.

(2) In limited circumstances, individuals who are required to complete a reapplication and a face-to-face interview every six months and the face-to-face interview cannot be completed, can have the interview completed by telephone. However, they must still complete a face-to-face interview at least once every twelve months.

(3) The CDHS shall conduct the face-to-face interview as described in Chapters 5101:1-2 and/or 5101:1-38 of the Administrative Code.

(4) For institutionalized recipients, the face-to-face interview for a reapplication may be conducted at the institution, by telephone, or at the CDHS with the institutionalized individual or authorized representative.

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CERTIFIED ELECTRONICALLY

Certification

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