TO BE RESCINDED

5101:1-38-01 **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 outlined in rule 5101:1-38-01.2 of the Administrative Code, or review of an application for assistance that does not require a face to face interview, and after the CDJFS has requested the verification and information required to establish the assistance group's (AG) eligibility for assistance, the CDJFS shall contact the 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 the CDJFS has not received the required information/verification and that, if the information/verification is not received within ten days, the CDJFS shall deny the application for medicaid.

(C) This written follow-up shall include a clear statement that the CDJFS 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 a JFS 07334 "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 CDJFS has not received the required information/verification and that, if the information/verification is not received by the CDJFS within twenty days, the CDJFS shall deny the application.

(E) Failure to verify 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 CDJFS has properly

advised the AG what information/verification is needed to determine eligibility and no request for assistance in obtaining information/verification was received by the CDJFS; or

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

(F) The CDJFS is responsible for determining eligibility for all medicaid programs with the exception of the Ohio breast and cervical project as outlined in rule 5101:1-41-05 of the Administrative Code.

(1) The CDJFS 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 that forty-five days may elapse between the date of application and an JFS 04074 "Notice of Approval of Your Application for Assistance" (or CRIS-E equivalent) or an JFS 07332 "Notice of Denial of Your Application for Medicaid in Cases Involving Community Spouse." 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 CDJFS must not use the time standards as a waiting period before determining eligibility.

(d) The CDJFS 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 CDJFS. The following circumstances are considered beyond the control of the CDJFS.

(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 CDJFS' 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 described in rule 5101:1-38-01.2 of the Administrative Code, all CDJFS' are required to use the following formats and forms for processing applications:

(a) Healthy start, expedited and healthy families/low income families (LIF) applications shall use:

(i) The JFS 07220, "Application/Redetermination Verification Request Checklist."

(ii) The JFS 07227, "Application Follow-up Letter."

(b) All other medicaid applications shall use:

(i) The JFS 07104 , "Application/Reapplication Verification Request;"

(ii) The JFS 07105, "Application/Reapplication Verification Request Checklist;"

(iii) ODJFS format application follow-up letter.

(2) Upon approval of medicaid, the following individuals must be referred to the local special supplemental 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) The following applications are used to refer individuals to WIC. Individuals currently on the WIC program need not be referred.

(a) A copy of the JFS 07216, "Combined Programs Application" (CPA).

(b) A copy of the JFS 01137, "Child Care/Healthy Start and Healthy Families Supplement.

(4) Upon approval of medicaid, each recipient must be given a JFS 07114, "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 healthy families/LIF, the AG must be given a copy of the JFS 07115, "Transitional Medicaid and Child Care notice."

(H) The redetermination process is a periodic review and confirmation that the AG 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, Ohio breast and cervical cancer project and Ohio's residential state supplement program (RSS). The redetermination process includes:

(1) Providing materials described in rule 5101:1-38-01.2 of the Administrative Code. The application form is not normally mailed with the materials unless the AG is not required to complete a face to face interview.

(a) A JFS 07100, Application for Income, Medical and Food Assistance," also known as the common application form (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 JFS 07216, CPA is issued for AGs that are in receipt of healthy start or healthy families/LIF.

(c) A JFS 07103, "Application for Help with Medicare Expenses," is issued for the AGs that are in receipt of only QMB, SLMB, QI-1 or QWDI.

(d) A JFS 07161, "Ohio Breast and Cervical Cancer Project Medicaid Application" is issued for AGs that are found to have breast or cervical cancer and require coverage while in treatment. Eligibility for this category of medicaid is limited to women diagnosed with breast or cervical cancer through the Ohio department of health breast and cervical project and is administered at ODJFS as outlined in rule 5101:1-41-03 of the Administrative Code.

(2) Conducting a face-to-face interview, if required. A face-to-face interview is not required for individuals in receipt of healthy start, healthy families/LIF, QMB, SLMB, QI-1, QWDI, the Ohio breast and cervical cancer project, institutionalized individuals or individuals in receipt of home and community based waiver services.

(3) The deadline for completing the application must be included in the application packet for all AGs who are not required to complete a face-to-face interview.

(4) Informing the AG of its required involvement and cooperation in the redetermination process.

(5) Providing an interpreter at no charge to the AGs with limited English proficiency.

(6) Reviewing basic eligibility factors and explaining rights, reporting responsibilities, healthchek, and social services as appropriate.

(7) All of the information in paragraph (H)(6) of this rule must be included in the redetermination packet for AGs that are not required to participate in a face-to-face interview.

(8) Obtaining verification of information that is new, has changed or is subject to change when required as outlined in Chapter 5101:1-38 of the Administrative Code.

(9) Completing the redetermination in a timely manner.

(10) Updating all county and state files upon completion of the redetermination process.

(I) The role of the CDJFS in the redetermination process:

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

(2) When the redetermination is to be completed with a CRIS-E interactive interview, the application form is not required to be sent to the AG. The CDJFS shall initiate the redetermination process by sending all materials outlined in rule 5101:1-38-01.2 of the Administrative Code.

(3) The CDJFS shall require a JFS 07200 or JFS 07216 is completed during the interactive interview when a new category of assistance or an additional category of assistance is needed or requested.

(4) The CDJFS 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 AG in the redetermination process:

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

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

(3) For the AGs identified in paragraph (H)(2) of this rule, a face-to-face interview is not required, however, they are required to provide the necessary verifications to establish continued eligibility.

(4) Upon request from the AG, the CDJFS shall provide assistance when the AG is not able to obtain requested information.

(5) Failure to verify occurs when the CDJFS properly requests verification which is not provided and the CDJFS 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 redetermination appointment also constitutes failure to cooperate in the redetermination process. Failure to cooperate in the redetermination process and/or with the verification requirements shall result in termination of medicaid as continued eligibility cannot be determined.

(K) A redetermination of eligibility is required every twelve months for medicaid for the aged, blind, and disabled, QMB, SLMB, QI-1, RSS, and healthy start. Redeterminations are required every six months for covered families and children medicaid with the following exceptions and considerations:

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

(2) A redetermination is not required for newborns if the newborn is eligible for medicaid in accordance with rule 5101:1-40-02.2 of the Administrative Code. A redetermination is to be scheduled at the end of the one year period of deemed eligibility.

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

(4) In multiple assistance cases, the redetermination 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 redetermination date for other assistance programs.

(5) Based upon a reasonable belief that circumstances have changed that may affect eligibility, a CDJFS may complete a redetermination or PTR in accordance with rule 5101:1-38-01.1 of the Administrative Code at any time other than the next regularly scheduled redetermination date. The CDJFS must document in the case record the reason(s) for requiring a redetermination at any time other than the six month or twelve month intervals as stated above.

(6) Inability to complete the redetermination 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 redetermination 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 CDJFS for all programs except healthy start, healthy families/LIF, expedited medicaid, QMB, SLMB, QI-1 and QWDI, institutionalized individuals and individuals in receipt of home and community based waiver service. 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 5101:1-38 of the Administrative Code.

(1) In limited and unusual situations, the CDJFS may experience a temporary delay in completing a redetermination because the face-to-face interview cannot be conducted. The CDJFS may complete the redetermination without conducting the face-to-face interview if continued eligibility can be determined without an interview. Only in extenuating circumstances may a redetermination 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 CDJFS' decision not to conduct an interview.

(2) In limited circumstances, individuals who are required to complete a redetermination 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 CDJFS shall conduct the face-to-face interview as described in rule 5101:1-38-01.2 of the Administrative Code.

(4) A face-to-face interview is not required for individuals who are institutionalized or are in receipt of home and community based waiver services. The interview can be completed via telephone, by the individual or authorized representative.

Replaces:	5101:1-37-02.3, 5101:1-38-01, 5101:1-38-01.2, 5101:1-38-02
Effective:	
R.C. 119.032 review dates:	06/23/2009

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Certification

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Date

Promulgated Under:	111.15
Statutory Authority:	5111.01, 5111.011, 5111.012
Rule Amplifies:	5111.01, 5111.011, 5111.012
Prior Effective Dates:	8/1/1975, 10/1/1975, 12/31/1977, 9/1/1982, 9/24/1983, 8/1/1984, 10/20/1984, 11/1/1984, 12/1/1984(Emer.), 2/10/1985, 8/1/1986, (Emer.), 10/3/1986, 10/1/1987(Emer.), 12/24/1987, 4/1/1988 (Emer.), 6/30/1988, 7/1/1988 (Emer.), 9/1/1988, 9/24/1988, 10/1/1988, (Emer.), 12/20/1988, 12/1/1989, 4/1/1991 (Emer.), 6/1/1991, 10/1/1991(Emer.), 12/20/1991, 4/1/1992, 7/1/1992, 1/1/1993, 5/1/1993, 3/1/1994(Emer.), 4/18/1994, 1/1/1995, 7/1/1995, 5/1/1997, 10/1/1997 (Emer.), 10/30/1997, 7/1/1998, 10/1/1999, 5/4/2000