5160:1-2-01 **Medicaid: administrative agency responsibilities.**

(A) This rule describes the responsibilities of the administrative agency.

(B) Calculation of time periods for eligibility determinations. All calculations of time periods used in the determination of eligibility, including scheduled renewals or a renewal as a result of a reported change, or any notice sent as a result of a determination 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.

(C) Effective date of applications, reported information, or requests for applications or assistance. Applications, documents, or information submitted or provided to the administrative agency, or requests made to the administrative agency, are considered received by the administrative agency:

(1) That day, if received before five p.m. on a business day, or if provided to the administrative agency during the administrative agency's office hours.

(2) On the next business day, if received by the electronic eligibility system after five p.m. or on a non-business day when the administrative agency is closed.

(D) Request for application. When an individual requests an application, the administrative agency must:

(1) Not deny an individual's right to apply or discourage an individual from applying.

(2) Inform the individual of the following:

(a) An online application portal is available to complete an application for medical assistance.

(i) Assistance completing the online application is available through the portal.

(ii) Use of the online application portal will likely lead to faster determination of eligibility.

(b) The beginning date of benefits depends on the date the signed application is submitted electronically or received by the administrative agency. The signature may be original, copied, facsimile, or electronic.

(c) The verification requirements and deadlines.

(d) Individuals must cooperate with eligibility determinations, renewals, audits and quality control processes as defined in this chapter of the Administrative Code.

(e) The meaning of and penalties for medicaid eligibility fraud as set forth in section 2913.401 of the Revised Code.

(3) Fulfill a request for an application within a business day.

(a) Fulfillment occurs when the administrative agency sends an electronic copy of the application or a link to an electronic copy of the application to the text or email address provided by the individual; hands the application to the individual; or places the application in the U.S. mail. If the application is provided in person or via U.S. mail, the administrative agency must enclose a preaddressed, postage-paid envelope for retun of the application.

(b) The application must be accompanied by the JFS 07217 "Voter Registration Notice of Rights and Declination" (rev.8/2009), or a notice meeting the requirements of section 3503.10 of the Revised Code, and a voter registration form as required by section 329.051 of the Revised Code.

(E) Upon a request for assistance or receipt of an application, the administrative agency must:

(1) Provide an interpreter at no charge to an individual with limited English proficiency and, when available, provide applications and important forms or brochures in the individual's language.

(2) Distribute voter information and registration materials as required by 42 C.F.R. 431.307 (as in effect on June 1, 2015).

(3) Coordinate with the special supplemental nutrition program for women, infants and children (WIC). Advise any potential WIC recipient of the WIC program and refer the individual to the WIC agency by forwarding a copy of the individual's medical assistance application and any supplemental application, unless the individual is already receiving WIC assistance.

(a) The following individuals are potential WIC recipients:

(i) A woman who is:

(a) Pregnant; or

(b) Within a six-month period after termination of pregnancy; or

(c) Breastfeeding her infant within twelve months after the infant's birth; or

(ii) A child younger than five years old.

(b) For any individual in receipt of medical assistance who is a potential WIC recipient, the administrative agency must advise the individual of the WIC program at least annually.

(F) Assistance.

(1) The administrative agency must allow a person or persons of the individual's choice to accompany, assist, and represent the individual in the application or renewal process.

(a) A person may accompany and assist an individual without being an individual's authorized representative.

(b) The administrative agency must not reveal safeguarded information, as described in rule 5160:1-1-03 of the Administrative Code, or send notices or correspondence to the person assisting the individual, unless the person has been designated in writing as an authorized representative.

(c) A person who is assisting an individual must provide accurate information, to the best of his or her knowledge, regardless of whether the person is an authorized representative.

(2) If an individual has designated in writing an authorized representative, the administrative agency must:

(a) Issue all notices and correspondence to both the authorized representative and the individual.

(b) Contact the individual to clarify or verify information provided by an authorized representative if the information provided on the application seems contradictory, unclear, or unrealistic.

(c) Remove the authorized representative from any correspondence or access to safeguarded information upon receipt of notice that:

(i) The authorized representative is declining or ending representation of the individual, or

(ii) The individual has withdrawn the representative's authority.

(3) The administrative agency must help complete the application if assistance is needed, including assistance through agents of the administrative agency, such as eligibility workers.

(a) At the individual's request, an eligibility worker must assist with completing the application by asking the individual for answers needed to complete the application, then recording the individual's answers on the application form or in the electronic eligibility system. The eligibility worker must not alter any answers given by the individual.

(b) If an eligibility worker assists or helps to complete an application, the worker must sign the application form, and include the worker's title, as a person who assisted in completing the application.

(c) The normal process of inputting data into the electronic eligibility system or determining an individual's eligibility must not be construed as providing assistance.

(4) Upon request, the administrative agency must provide assistance to individuals having difficulty gathering verifications.

(5) When determining eligibility for an individual with a physical or mental impairment that substantially limits the individual's ability to access verifications, and who has not granted any person durable power of attorney, or who does not have a court-appointed guardian or a person with other legal authority and obligation to act on behalf of the individual, the administrative agency must:

(a) Determine if another person is available to assist with obtaining verifications or accessing the individual's means of self-support.

(i) If such a person is available, request the person assist with obtaining the verifications or accessing the individual's means of self-support.

(ii) If verifications are provided, or if means of self-support are accessed by the individual or on the individual's behalf by another person, the administrative agency must consider the verified criteria or means or self-support in the eligibility determination process.

(b) If no person is available to assist the individual:

(i) Refer the individual's case to the administrative agency's legal counsel and request counsel evaluate whether the matter should be referred to the probate court, adult protective services, or

another entity deemed by the administrative agency's legal counsel to be appropriate. For cases referred to counsel for such evaluation, the administrative agency must also:

(a) Note in the individual's case record that verifications or means of self-support are not available and must not be considered a disqualifying factor until a means of access to those items is obtained or established, and

(b) Inform the administrative agency's legal counsel of any eligibility approval or denial.

(ii) Determine eligibility in accordance with Chapter 5160:1-2 of the Administrative Code, but without considering eligibility factors for which verification cannot be obtained or means of self-support that cannot be accessed because of the physical or mental impairment. Use the most reliable information available without delaying the determination of eligibility.

(iii) Redetermine eligibility once a means of access to verifications or means of self-support is obtained or established. If such access has not been obtained prior to a regularly-scheduled renewal, determine continuing eligibility using the most reliable information available.

(G) Receipt of application. Upon receipt of any signed application for medical assistance or for specific medical assistance services or programs, the administrative agency must:

(1) Give or send a receipt to the individual showing the date of application.

(2) Accept and register an application within a business day of the time the signed application is received, whether it is an original, a facsimile, a telephonic, or an electronic signature ("e-signature"). An original signature is not required.

(a) If an application is received from a local WIC clinic, child and family health services (CFHS) clinic, or bureau for children with medical handicaps (BCMH) office within five working days of the signature date, the application must be registered using the signature date. If the application is not received within five working days of the signature date, the application must be registered using the date it was received by the administrative agency.

(b) If an application taken by an outstationed worker assigned to a federally qualified health center (FQHC) or a disproportionate share hospital (DSH) was not directly entered into the electronic eligibility system, it must immediately be submitted to the appropriate administrative

agency, which must register the application using the signature date.

(3) The administrative agency must not delay the registration or processing of an application due to the lack of a signed acknowledgement of an individual's rights and responsibilities.

(4) If not previously provided, give or send a notice meeting the requirements of section 3503.10 of the Revised Code or JFS 07217, voter registration form as required by section 329.051 of the Revised Code.

(H) Verifications. Where manual verifications are required under rule 5160:1-2-10 of the Administrative Code, the administrative agency must:

(1) Follow the safeguarding guidelines set forth in rule 5160:1-1-03 of the Administrative Code when providing or gathering information by telephone, in person, or in electronic or written form.

(2) Not require that an individual provide verification of unchanged information unless the information is incomplete, inaccurate, inconsistent, outdated, or missing from the case record due to record retention limitations.

(3) Not request that an individual provide duplicate copies of previously submitted verifications.

(4) To the extent possible, verify relevant eligiblity criteria using electronic records available through the electronic eligibility system. Where electronic verification is not available, or electronic verification data conflicts with the individual's attestation, request verifications as set out in rule 5160:1-2-10 of the Administrative Code.

(5) If the administrative agency is unable to verify an eligibility criteria through electronic sources, the administrative agency will provide a written (electronic or on paper) request for the necessary information or verification documents.

(a) The written request must:

(i) Include the date by which the information must be provided to the administrative agency;

(ii) Inform the individual that any delay in providing requested information or documents will delay the determination of an individual's eligibility; and

(iii) Provide information on how an individual can request assistance in gathering the requested documents.

(a) The administrative agency must assist the individual in obtaining the verifications required for eligibility determination.

(b) When the normal sources of verification described in this rule have been exhausted and no documentation can be obtained, the administrative agency may accept the individual's statement if it is complete and consistent with other facts and statements. The use of such a statement must be on a case by case basis when no other approach is possible, and must be used only in rare circumstances.

(b) If the information or verification required to establish the individual's eligibility for assistance is not received by the administrative agency by the stated date, the administrative agency must contact the individual in writing no more than twenty calendar days from the date of the application.

(i) The follow-up letter:

(a) Must be sent electronically, via postal mail or personally delivered to the individual;

(b) Must state that the required information or verification has not been received, and that if the information or verification is not received within ten calendar days the administrative agency shall deny the application for medical assistance; and

(c) Must include a clear statement that the administrative agency will assist with obtaining the required information or verification if the request for assistance is received on or prior to the given deadline; and

(d) Does not serve as a notice of denial of application.

(ii) If the requested information or verification is not received by the stated deadline, the administrative agency shall propose a denial or termination of benefits.

(c) The administrative agency must deny the individual's application if the individual fails to provide the necessary information or verifications, or request assistance and cooperate with obtaining verifications, within the time specified in the second verification request. If this happens:

(i) An individual may reapply at any time.

(ii) An individual should not be asked to re-verify information previously verified by the administrative agency without reason to believe the information may have changed.

(6) Give or send a dated itemized receipt for any verification document received from an individual.

(7) Record receipt of all verification documents, photocopy or scan the documents, and retain copies or images of the documents in the case record.

(8) If information is verified through a telephone contact, record the following details:

(a) The name and telephone number of the person giving the information;

(b) The name of the agency or business contacted, if applicable;

(c) The date of the contact; and

(d) An accurate summary of the information provided.

(I) Determination and renewal of eligibility. The administrative agency must:

(1) Not schedule an interview except at the request of the applicant.

(2) Inform all individuals at the time of application and renewal that the agency will obtain and use information available from IEVS to assist with the determination of eligibility, as required by section 1137 of the Social Security Act (as in effect on June 1, 2015).

(3) Using the electronic eligibility system, the administrative agency must:

(a) Determine eligibility or renewal of an individual's eligibility for medical assistance within the application processing time limits set forth in this rule.

(i) The administrative agency must not approve medical assistance to an individual merely because of an agency error or delay in determining eligibility. All eligibility factors must be met.

(ii) The administrative agency must not delay the approval of medical assistance due to the lack of information or verifications necessary to determine eligibility for other public assistance programs.

(b) Document and record determinations of eligibility. The administrative

agency must:

(i) Record, in physical or electronic case records, any information, action, decision, or delay in the application, eligibility determination, or termination processes, as well as the reasons for any action, decision, or delay.

(ii) Make the case records, physical or electronic, available for compliance audits.

(c) Approve medical assistance for an individual who:

(i) Has signed an application under penalty of perjury; and

(ii) Has provided all necessary verifications as set forth in rule 5160:1-2-10 of the Administrative Code; and

(iii) Meets all conditions of eligibility for an eligibility category set forth in an approved state plan amendment, Chapter 5160:1-2, 5160:1-3, 5160:1-4, or 5160:1-5 of the Administrative Code. If an individual who attests to U.S. citizenship or qualified alien status meets all conditions of eligibility for an eligibility category except for verification of the individual's citizenship or qualified alien status, the administrative agency must approve time-limited coverage during a reasonable opportunity period (ROP) as required in rule 5160:1-2-11 or 5160:1-2-12 of the Code.

(d) Deny an application for medical assistance for an individual who:

(i) Has not signed an application under penalty of perjury; or

(ii) Withdraws the application; or

(iii) Fails to cooperate in the application or determination process or fails to provide all necessary verifications set forth in rule 5160:1-2-10 of the Administrative Code; or

(iv) Does not meet all conditions of eligibility for any eligibility category set forth in Chapter 5160:1-2, 5160:1-3, 5160:1-4, or 5160:1-5 of the Administrative Code.

(e) Suspend medical assistance upon notification that an individual meets any of the criteria for ineligibility for payment of services set forth in rule 5160:1-1-05 of the Administrative Code.

(f) Terminate medical assistance for an individual who:

(i) Requests that assistance be terminated; or

(ii) Is no longer an Ohio resident, or is deceased; or

(iii) Fails to cooperate in the renewal process; or

(iv) Fails to cooperate in the quality control process; or

(v) Fails to provide all necessary verifications; or

(vi) Is eligible as a result of an administrative agency error, or

(vii) Provided fraudulent information or verifications, or

(viii) Fails or refuses to comply with individual responsibilities as described in this chapter of the Administrative Code, or is subject to an OWF sanction and has not agreed to comply with the work requirements; or

(ix) No longer meets the conditions of eligibility for an eligibility category as set forth in Chapter 5160:1-2 of the Administrative Code. Before terminating coverage on this basis, the administrative agency must conduct a pre-termination review (PTR) to determine that the individual is no longer eligible for coverage under any eligibility category.

(J) Reinstatement of medical assistance when an individual cooperates with the renewal process.

(1) The administrative agency must reinstate medical assistance, terminated for failure to cooperate in the renewal process or verfication of a reported change, within ninety calendar days of the termination date without requiring a new application in accordance with 42 C.F.R. 435.916(a)(3)(C)(iii) (as in effect on June 1, 2015).

(2) The administrative agency must accept the renewal form and/or verifications that caused the termination of medical assistance.

(3) The administrative agency must reinstate medical assistance if all eligibility criteria are met.

(4) Reinstated medical assistance coverage shall begin on the first day of the calendar month following the month medical assistance was terminated.

(K) Timely determinations and renewals. The administrative agency must make a timely determination of an individual's eligibility for medical assistance under this chapter

of the Administrative Code. The administrative agency must determine initial eligibility or a renewal of eligibility, including obtaining verifications when required, within:

(1) Ten calendar days of receiving a report of a change that could affect an individual's on-going eligibility for medical assistance; or

(2) Thirty calendar days from the date of application or scheduled renewal, unless:

(a) An individual who otherwise meets the conditions of eligibility described in this chapter of the Administrative Code alleges blindness or disability. The administrative agency must determine eligibility within ninety calendar days from the date of application unless the examining physician delays or fails to take a required action; or

(b) There is an administrative or other emergency beyond the administrative agency's control.

(3) Forty-five calendar days of receipt of new or changed information from IEVS. The administrative agency must not terminate, deny, or suspend benefits until appropriate steps have been taken to verify the relevant information in accordance with 42 C.F.R. 435.952(d) (as in effect on June 1, 2015).

(L) Effective dates of eligibility.

(1) Medical assistance coverage begins on the first day of the calendar month in which the application which resulted in eligibility was submitted to the administrative agency, except that:

(a) An individual's coverage cannot begin before the date on which the individual:

(i) Became a resident of Ohio, or

(ii) Was born.

(b) The administrative agency must approve retroactive eligibility for medical assistance effective no later than the first day of the third month before the month of application if the individual:

(i) Received medical services of a type covered by medicaid at any time during that period; and

(ii) Would have been eligible for medical assistance at the time the services were provided if an application had been made at that time, regardless of whether the individual was alive when the application actually was made.

(iii) Is eligible for a category of medical assistance other than:

(a) Transitional medicaid as described in rule 5160:1-4-05 of the Administrative Code; or

(b) Medicare premium assistance as described in rule 5160:1-3-02.1 of the Administrative Code; or

(c) Any presumptive eligibility category described in rule 5160:1-2-13 of the Administrative Code.

(2) Medical assistance coverage terminates on the last day of a calendar month, except that coverage terminates on the date an individual:

(a) Becomes a resident of another state;

(b) Dies; or

(c) Requests that coverage be terminated.

(M) Duration of eligibility span. The administrative agency must:

(1) Terminate coverage under a time-limited eligibility category as described in the Administrative Code rule for the appropriate eligibility category. These time-limited eligibility categories include:

(a) Any presumptive eligibility category, described in rule 5160:1-2-13 of the Administrative Code, and

(b) Alien emergency medical assistance, as described in rule 5160:1-5-06 of the Administrative Code, and

(c) Refugee medical assistance, described in rule 5160:1-5-05.

(2) Determine an individual's eligibility for a renewal of medical assistance on the earlier of the following:

(a) Twelve months after the most recent eligibility determination, or

(b) Upon receiving a report of a change in circumstances that could affect an individual's eligibility for medical assistance.

(N) Third party liability (TPL). For individuals found eligible for or in receipt of medical assistance, the administrative agency must report to the Ohio department of medicaid (ODM) any available information about a third party liable for an individual's health care costs.

(1) When determining an individual's eligibility for medical assistance coverage, the agency must use the form (or an electronic equivalent) designated by the administrative agency to report:

(a) Possible health insurance coverage of an individual. A separate report must be made for each possible health insurance policy.

(b) Potential TPL due to an injury, disability or court order.

(2) At a renewal, or upon any reported change, the administrative agency must compare the individual's current information to the information on the most recent ODM 06612"Health Insurance Information Sheet" (rev. 07/2014) or ODM 06613"Accident/Injury Insurance Information (rev. 07/2014). If any information has changed, the administrative agency must report the changes to ODM by submitting a new ODM 06612 or ODM 06613, or an electronic equivalent.

(3) Upon a request by ODM, the administrative agency must contact the individual to obtain information about potential TPL. If the individual fails to cooperate, the agency must propose to terminate or deny the individual's medical assistance for failure to cooperate, as set forth in paragraph (I)(3) of this rule.

(O) Upon a report (verbal or written) of a change of address within the state of Ohio, the administrative agency must:

(1) Give or mail to the individual a notice meeting the voter registration requirements of section 3503.10 of the Revised Code, and advise the individual that, upon request, the administrative agency will help the individual register to vote or update voter registration as outlined in rule 5101:1-2-15 of the Administrative Code.

(2) Process an intercounty transfer (ICT) if the individual has changed residence from one county to another. Both the county of original residence and the county of new residence have responsibilities in the ICT process. The ICT process shall be followed whether the individual reporting a change of residence is an applicant or is currently in receipt of medical assistance benefits.

(a) The CDJFS receiving report of a move shall determine whether the move is a change of residence or a temporary absence from the home. If the move is a temporary absence from the home, the county in which the individual is physically located shall provide necessary medical and transportation services.

(b) The CDJFS receiving report of a change of residence shall:

(i) Update the address in the electronic eligibility system. If the individual does not have an address in the new county, use the address of the administrative agency in the new county.

(ii) If the report was made to the administrative agency in the county of new residence, inform the county of original residence.

(c) The CDJFS in the county of original residence shall transfer the case in its current status in the electronic eligibility system within five working days of the reported change. If any case records or physical or electronic documents are maintained by the CDJFS outside of the electronic eligibility system, the CDJFS shall:

(i) Transfer the case records, or a physical or electronic copy of the records, to the county of new residence within fifteen working days of the reported change. The case record to be transferred shall contain the original (or, if the administrative agency uses an imaging system, a scanned image) of the following documents:

(a) The most recently signed application for medical assistance benefits; and .

(b) Other pertinent documents, such as citizenship, income or resource verifications

(ii) Complete a notice of intercounty transfer, attach a copy of the notice to the records being transferred to the county of new residence, and keep a copy of the notice in the retained case record.

(iii) Maintain a copy of transferred documents for future reference, while providing original documents, to the extent available, to the county of new residence.

(d) The CDJFS in the county of new residence shall:

(i) Not require the individual to reapply or cooperate with a renewal of eligibility for medical assistance merely due to the change in county of residence.

(ii) Provide the medical assistance benefits for which the individual is eligible.

(iii) Perform the periodic renewal or renewal upon a change in circumstances as outlined in this rule.

(e) If the case being transferred is subject to a claim for overpayment as set out in rule 5160:1-2-04 of the Administrative Code:

(i) An existing claim shall not be transferred. The records transferred to the CDJFS in the county of new residence shall include copies of the documentation of the claim. The CDJFS establishing the claim remains responsible for any necessary action on the claim.

(ii) If no claim has been established and the CDJFS in each county agrees that the county of new residence shall establish the claim, then a potential claim may be transferred to the CDJFS in the county of new residence to be established by the CDJFS in that county.

(P) Distribution of informational materials. The administrative agency:

(1) Must issue proper notice and hearing rights as outlined in division 5101:6 of the Administrative Code.

(2) Must distribute to individuals the ODM 1095-B "Health Coverage" in January of each calendar year and upon an individual's request.

(3) Must distribute materials to individuals in accordance with 42 C.F.R. 431.307 (as in effect on June 1, 2015).

(4) May distribute materials directly related to the health and welfare of applicants and beneficiaries, such as announcements of free medical examinations, availability of surplus food, and consumer protection information.

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