TO BE RESCINDED

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

(A) This rule sets forth responsibilities of the individual and the administrative agency that apply at all times: at application; at the initial eligibility determination; at a scheduled or unscheduled redetermination; and between redeterminations.

(B) Individual responsibilities. The individual shall:

(1) Provide verification of all eligibility criteria as requested by the administrative agency.

(2) Report to the administrative agency, within ten days of the change, any change in the following:

(a) Household composition, living arrangements, or address.

(b) Earned or unearned income, including:

(i) The receipt of a non-recurring lump-sum payment; or

(ii) A change in employment status, including a change in hourly wage or salary, full- or part-time status, new employment, or loss of employment.

(c) Third-party liability for health care costs, including:

(i) New coverage under a health insurance policy, regardless of who is paying for the coverage; or

(ii) A change in health insurers; or

(iii) A court order requiring a person or entity pay some or all of an individual's medical expenses; or

(iv) Any accident or injury for which another person or entity may be responsible, such as a work-related injury or an injury sustained in an automobile collision; or

(v) Any insurance information as it relates to paragraph (B)(2)(c)(iv) of

this rule.

(vi) Termination of a health insurance policy.

(d) An individual's pregnancy status, such as an individual becoming pregnant or a pregnancy ending.

(e) An improvement of the individual's condition, if the individual is receiving medicaid for the blind or medicaid for the disabled.

(f) For any category of medical assistance with a resource limitation:

(i) A change in the ownership of a resource; or

(ii) A change in the amount or value of any available resource; or

(iii) Any change in ownership an individual or spouse has in an annuity, or any change to the remainder beneficiary designation.

(3) Cooperate with the application, determination, redetermination, auditing, and quality control processes, including:

(a) Completing, signing, and dating an initial application; and

(b) Answering all relevant questions and providing the necessary verifications to establish initial or continued eligibility; and

(c) Requesting assistance from the administrative agency if the individual is unable to obtain requested information, and providing the information necessary for the administrative agency to assist.

(4) Select a managed care plan (MCP) in accordance with rule 5101:3-26-02 of the Administrative Code, unless the individual falls within one of the exceptions listed in that rule.

(5) Cooperate with third-party insurance companies.

(C) Administrative agency responsibilities. The administrative agency shall:

(1) Render assistance and determine eligibility and benefits without discrimination

on account of race, religion, disability, national origin, political beliefs, age, or sex.

(2) Determine or redetermine an individual's eligibility for medical assistance within the application processing time limits set forth in rule 5101:1-38-01.2 of the Administrative Code.

(3) Not approve medical assistance to an individual merely because of an agency error or delay in determining eligibility, unless all eligibility factors are met.

(4) Determine eligibility for medical assistance promptly upon receipt of required information and verifications. The administrative agency shall not delay the approval of medical assistance due to the lack of information or verifications necessary to determine eligibility for other public assistance programs.

(5) Upon request, provide assistance to individuals having difficulty completing an application or gathering verifications.

(6) Advise applicants, authorized representatives, and individuals of:

(a) The effect of any delay in completing an application upon the starting date of potential medical coverage; and

(b) Verification requirements and time lines; and

(c) The requirement that the individual or authorized representative cooperate with the eligibility determination and redetermination process; and

(d) The penalties for medicaid eligibility fraud set forth in section 2913.401 of the Revised Code.

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

(8) Determine whether the individual's eligibility for medical assistance is affected by a change. This determination shall be made within ten days of learning of the change through data systems, a report from an individual, or by other means.

(9) If an individual reports a new address in the state of Ohio, the administrative

agency shall:

(a) Give or mail to the individual a notice meeting the requirements of section 3503.10 of the Revised Code; and

(b) Give or mail to the individual a voter registration form as required by section 329.051 of the Revised Code; and

(c) 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.

(10) Obtain verification of reported information that is new, has changed or is subject to change. Verification shall be obtained as set forth in Chapter 5101:1-38 of the Administrative Code.

(11) Issue an itemized, dated receipt when an application for medical assistance or a verification document related to eligibility for medical assistance is received.

(12) Document and record determinations of eligibility. The administrative agency shall:

(a) 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.

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

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

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

(e) 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.

(f) If information is verified through a telephone contact, record the following data:

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

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

(iii) The date of the contact; and

(iv) An accurate summary of the information provided.

(13) Approve medical assistance for an individual who:

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

(b) Has provided all necessary verifications as set forth in rule 5101:1-38-01.2 of the Administrative Code; and

(c) Meets all conditions of eligibility for a covered group set forth in rule 5101:1-38-01.8 of the Administrative Code.

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

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

(b) Withdraws the application; or

(c) Fails to cooperate in the application or determination process or fails to provide all necessary verifications, as set forth in paragraph (H)(4) of rule 5101:1-38-01.2 of the Administrative Code; or

(d) Does not meet all conditions of eligibility for any covered group as set forth in rule 5101:1-38-01.8 of the Administrative Code.

(15) Suspend medical assistance upon notification that an individual meets any of the criteria for ineligibility for payment of services set forth in rule 5101:1-37-20 of the Administrative Code. Redetermine eligibility upon

notification that an individual no longer meets the previously cited criteria.

(16) Terminate medical assistance for an individual who:

(a) Requests that assistance be terminated; or

(b) Is deceased; or

(c) Fails to cooperate in the redetermination or quality control processes, or fails to provide all necessary verifications; or

(d) No longer meets the conditions of eligibility for any covered group as set forth in rule 5101:1-38-01.8 of the Administrative Code.

(17) Notify individuals of all determinations and proposed changes in coverage or benefits, including any applicable premium, patient liability, or spenddown.

(18) Follow the safeguarding guidelines set forth in rule 5101:1-37-01.1 of the Administrative Code when providing or gathering information by telephone, in person, or in electronic or written form.

(19) Process an intercounty transfer (ICT) upon receipt of a report (verbal or written) that an individual has changed residence from one county to another within the state of Ohio. 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:

(i) Transfer the case in its current status in the electronic eligibility system within five working days of the reported change.

(ii) Transfer the case records, or a physical or electronic copy of the records, to the county of new residence within fifteen 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.

(iii) Complete a JFS 03900 "Notice of Intercounty Transfer" (rev. 5/2010), attach a copy of the JFS 03900 to the records being transferred to the county of new residence, and keep a copy of the JFS 03900 in the retained case record.

(iv) Maintain a copy of transferred documents for future reference, while making originals available, 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 reapply or cooperate with a redetermination 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 redetermination or redetermination upon a change in circumstances as outlined in rule 5101:1-38-01.2 of the Administrative Code.

(e) If the case being transferred is subject to a claim for overpayment as set out in rule 5101:1-38-20 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) A potential claim, which has not yet been established, may be transferred to the CDJFS in the county of new residence, for that CDJFS to establish, only if the CDJFS of both counties agree that the county of new residence shall establish the claim.

(20) Advise potentially eligible individuals of the supplemental nutrition program for women, infants and children (WIC) and refer them to the WIC agency by forwarding a copy of the individual's medicaid 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 the 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 shall advise the individual of the WIC program at least annually.

(21) Report to the Ohio department of job and family services (ODJFS) any available information about a third party liable for an individual's health care costs.

(a) When determining an individual's eligibility for medical assistance coverage, the agency shall report any potential third-party liability (TPL) to the ODJFS using:

(i) The JFS 06612 "Health Insurance Information Sheet" (rev. 5/2001), or its electronic equivalent, to report possible health insurance coverage. A separate JFS 06612 shall be completed for each possible health insurance policy.

(ii) The JFS 06613 "Accident/Injury Insurance Information Form" (rev. 6/2009), or its electronic equivalent, to report potential TPL due to an injury, disability or court order.

(b) At a redetermination, or upon any reported change, the administrative agency shall compare the individual's current information to the information on the most recent JFS 06612 or JFS 06613. If any information has changed, the administrative agency shall report the changes to ODJFS by submitting a new JFS 06612 or JFS 06613, or an electronic equivalent.

(c) Upon a request by ODJFS, the administrative agency shall contact the individual to obtain information about potential TPL. If the individual fails to cooperate, the agency shall propose to terminate or deny the individual's medical assistance for failure to cooperate, as set forth in rule 5101:1-38-01.2 of the Administrative Code.

(22) Issue proper notice and hearing rights as outlined in division 5101:6 of the Administrative Code.

Effective: 01/15/2015

Five Year Review (FYR) Dates: 10/30/2014

CERTIFIED ELECTRONICALLY

Certification

01/05/2015

Date

Promulgated Under: 111.15
Statutory Authority: 5111.01, 5111.011, 5111.012
Rule Amplifies: 5111.01, 5111.011, 5111.012, 329.051
Prior Effective Dates: 11/1/74, 8/1/75, 10/1/75, 6/1/76, 7/14/77, 12/31/77, 9/1/82, 9/24/83, 8/1/84, 10/20/84, 11/1/84, 12/1/84 (Emer.), 2/10/85, 7/1/85, 4/1/86, 8/1/86 (Emer.), 10/3/86, 10/1/87 (Emer.), 12/24/87, 4/1/88 (Emer.), 6/10/88, 6/30/88, 7/1/88 (Emer.), 8/1/88 (Emer.), 9/1/88, 9/24/88, 10/1/88 (Emer.), 10/15/88, 10/25/88 (Emer.), 12/20/88, 3/1/89 (Emer.), 5/28/89, 12/1/89, 4/1/90 (Emer.), 6/22/90, 8/1/90 (Emer.), 10/25/90, 1/1/91 (Emer.), 2/21/91, 4/1/91 (Emer.), 6/1/91, 7/1/91 (Emer.), 9/15/91, 10/1/91 (Emer.), 12/20/91, 4/1/92, 7/1/92, 1/1/93, 1/1/93 (Emer.), 2/11/93, 3/18/93, 5/1/93, 9/1/93, 1/1/94, 3/1/94 (Emer.), 4/18/94, 1/1/95, 1/1/95 (Emer.), 4/1/95, 7/1/95, 10/1/95, 6/1/96, 10/1/96, 10/1/96 (Emer.), 12/15/96, 5/1/97, 10/1/97 (Emer.), 10/30/97, 12/30/97, 7/1/98, 7/1/99, 10/1/99, 5/4/00, 7/1/00, 6/1/03, 6/1/03 (Emer.), 9/20/03, 10/6/03, 9/25/06, 10/1/06, 6/1/07, 8/1/07, 10/1/09, 7/17/11