5160:1-2-13 **Medicaid: presumptive eligibility.**

(A) This rule describes the conditions under which an individual may receive time-limited medical assistance as a result of an initial, simplified determination of eligibility based on the individual's self-declared statements.

(B) Eligibility criteria for presumptive coverage.

(1) Except as set forth in paragraph (B)(2) of this rule, an individual is eligible for presumptive coverage if the individual:

(a) Is a resident of the state of Ohio; and

(b) Is a U.S. citizen or has an immigration status as defined in rule 5160:1-2-12 of the Administrative Code that allows for medicaid eligibility; and

(c) Meets the non-financial eligibility criteria for a group set out in rule 5160:1-4-02, 5160:1-4-03, 5160:1-4-04, or 5160:1-4-05 of the Administrative Code, except that a simplified determination of household composition will be done, whereby household composition comprises the individual and, if living in the home:

(i) The individual's spouse;

(ii) The individual's children under age nineteen; and

(iii) If the individual is under age nineteen:

(a) The individual's parents; and

(b) The individual's siblings under the age of nineteen.

(d) Has gross family income, for the individual's family size, of no more than the eligibility limit set out for the relevant eligibility group in rule 5160:1-4-02, 5160:1-4-03, 5160:1-4-04, or 5160:1-4-05 of the Administrative Code.

(2) Limitations. An individual is ineligible for a subsequent presumptive coverage period for twelve months beginning on the date of a presumptive coverage determination, except that a woman may receive presumptive coverage based on pregnancy once during each pregnancy.

(C) Duration and scope of presumptive coverage.

(1) Presumptive coverage begins on the date an individual is determined to be presumptively eligible. No retroactive coverage may be provided as a result of a presumptive eligibility determination.

(2) Presumptive coverage ends on the earlier of (and includes):

(a) The date the administrative agency determines that the individual is eligible or ineligible for ongoing medical assistance pursuant to rule 5160:1-2-01 of the Administrative Code; or

(b) If an application for ongoing medical assistance for the individual has not been filed, the last day of the month following the month in which the individual was determined to be presumptively eligible.

(3) Presumptive eligibility services for individuals found presumptively eligible on the basis of pregnancy are restricted to ambulatory prenatal care.

(D) State agency responsibilities. The Ohio department of medicaid (ODM) must:

(1) Provide qualified entities (QEs), as defined in rule 5160:1-1-01 of the Administrative Code, with:

(a) Such forms as are necessary for applications to be submitted for medical assistance under the state plan; and

(b) Information on how to assist individuals in completing and filing such forms.

(2) Monitor the performance of each QE, as specified in the presumptive coverage addendum to their operating agreement, to determine that the QE has provided appropriate assistance to presumptively eligible individuals.

(3) Determine if a QE is in compliance with the presumptive coverage addendum to their operating agreement and notify any QE found to be out of compliance that the QE is no longer authorized to determine presumptive eligibility.

(E) Qualified entity (QE) responsibilities.

(1) If the QE is ODM or a ~~CDJFS:~~ county department of job and family services (CDJFS):

(a) No later than the end of the business day after receipt of a signed and dated application for medical assistance on behalf of an individual, ODM or the CDJFS must determine, based on the individual's self-declared

information, whether an individual is eligible for presumptive coverage under this rule.

(b) If an individual is eligible for presumptive coverage, ODM or the CDJFS must:

(i) Approve presumptive coverage for the individual; and

(ii) Inform the individual of:

(a) The presumptive coverage, and

(b) That failure to cooperate with the eligibility determination process set forth in rule 5160:1-2-01 of the Administrative Code will result in a denial of medical assistance, which will trigger the termination of presumptive coverage.

(c) If an individual is not eligible for presumptive coverage, ODM or the CDJFS must inform the individual that the individual's eligibility for medical assistance will be determined.

(d) Whether or not an individual is eligible for presumptive coverage, ODM or the CDJFS must determine whether the individual is eligible for ongoing medical assistance pursuant to rule 5160:1-2-01 of the Administrative Code.

(2) If the QE is a hospital, department of youth services (DYS), federally-qualified health center (FQHC), FQHC look-alike, local health department, WIC clinic, or other entity as designated by the director as defined in rule 5160:1-1-01 of the Administrative Code:

(a) Upon request, or if the QE believes the individual may meet the criteria for presumptive eligibility, determine whether the individual is presumptively eligible under this rule. Such determination shall not be delegated to a third party, but shall be done by the QE.

(b) Accept self-declaration of the presumptive eligibility criteria unless contradictory information is provided to or maintained by the QE.

(c) If the individual is presumptively eligible:

(i) Approve presumptive coverage for the individual using the electronic eligibility system designated by ODM in the presumptive eligibility operating addendum to the QE's provider agreement; and

(ii) Provide the individual, at the time of determination, with a notice of the individual's presumptive eligibility. Such notice must include the individual's:

(a) Presumptive eligibility determination date;

(b) Basis for presumptive eligibility;

(c) Name, date of birth, and address;

(d) Medicaid information technology system (MITS) billing number; and

(e) A reminder that the individual must apply for ongoing medical assistance no later than the last day of the following month.

(iii) Take all reasonable steps to help the consumer complete the application for ongoing medical assistance or make contact with the CDJFS.

(d) If the individual is not presumptively eligible, inform the individual that there may be other categories of medical assistance available to the individual, and that the individual should apply for a full determination of eligibility for medical assistance.

(e) Disqualification of QEs. A QE may be disqualified if ODM finds that a QE is not:

(i) Making, or is not capable of making, presumptive eligibility determinations, or

(ii) Complying with the QE responsibilities as described in this rule and in any agreement required by ODM.

(3) If the QE is a hospital, in addition to the eligibility criteria identified in paragraph (B)(1) of this rule, the hospital may also make presumptive eligibility determinations for the group set out in rule 5160:1-6-03.1 of the Administrative Code.

(F) Denial of presumptive coverage is not grounds for a state hearing under division 5101:6 of the Administrative Code.

(G) This rule is being filed as an emergency rule for the immediate preservation of the public health in order to provide greater flexibility to ensure medicaid eligible individuals

are able to quickly and efficiently obtain and maintain medicaid services during the COVID-19 state of emergency.

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CERTIFIED ELECTRONICALLY

Certification

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Date

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