Ohio | Department of Medicaid

Mike DeWine, Governor
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MEDICAID ELIGIBILITY MANUAL TRANSMITTAL LETTER (MEMTL) NO. TBD

To: **All Medicaid Eligibility Manual Holders**

From: **Maureen M. Corcoran, Director**

Subject: **Medicaid: Resuming Routine Operations Batch 1**

This MEMTL contains four rules that are being amended from Chapters 5160:1-2, 5160:1-3, and 5160:1-5 of the Administrative Code, adopted under section 111.15 of the Revised Code. All of the rules are being evaluated as part of a five-year review in accordance with section 111.15 of the Revised Code.

These rules are also being proposed for amendment to comply with the Consolidated Appropriations Act, 2023 (CCA, 2023) that sets an end date for the Families First Coronavirus Response Act (FFCRA) continuous coverage condition effective March 31, 2023.

The information contained in this clearance transmittal is for informational purposes only and is not intended to be part of the clearance review. Your review of and comments on the attached material are appreciated.

The following Ohio Administrative Code (OAC) rules are being amended:

Chapter 2

5160:1-2-08 Medicaid: Individual Responsibilities

Proposed changes to this rule include restoring the reporting requirements for marital status, one-time gifts, and new employment. The term “his or her” was changed to “an individual’s”. The term “managed care plan” was updated to “managed care organization”. This rule was also evaluated for a five-year review and minor grammatical modifications were made for clarity.

5160:1-2-14 Medicaid: Continuous Eligibility for Children Younger than Age Nineteen

Proposed changes to this rule include restoring language regarding termination of the continuous eligibility period when a child reaches age nineteen or an individual fails to pay a Medicaid Buy-In for Workers with Disabilities (MBIWD) premium. The term “alien” was changed to “non-citizen”. This rule was also evaluated for a five-year review and minor grammatical modifications were made for clarity.

Chapter 3

5160:1-3-02.2 Medicare Buy-In

Proposed changes to this rule include restoring the process for termination from the Medicare Buy-In program. This rule was also evaluated for a five-year review and minor grammatical modifications were made for clarity.

Chapter 5

5160:1-5-08 Medicaid: State-Funded Medical Assistance for Non-Citizen Victims of Trafficking

Proposed changes to this rule include restoring language indicating that eligibility for medical assistance will be discontinued if the individual fails to file a formal application for "T" non-immigration status within one year of the application for medical assistance. This rule was also evaluated for a five-year review and minor grammatical modifications were made for clarity.

Fiscal Impact

The Ohio Department of Medicaid (ODM) supplies funding to Ohio's counties through the Ohio Department of Job and Family Services, which funds counties to conduct eligibility determinations and complete casework for the Medicaid program. The revisions to the rules in this clearance do not impose any new requirements on county agencies and the implementation of these rule changes should result in no fiscal impact on the county agencies.

Training Statement

The revisions to the rules in this clearance will require training or technical assistance to be provided to county staff by ODM. Clarification regarding these rules will be available to county staff through Medicaid Eligibility Technical Assistance staff.

DRAFT - NOT FOR FILING

5160:1-2-08 Medicaid: individual responsibilities.

(A) This rule describes the responsibilities of an individual, or someone acting on ~~his or her~~an individual's behalf, who is applying for or receiving medical assistance.

(B) Individual responsibilities.

(1) When applying for or receiving any medical assistance, an individual must:

(a) Sign, under penalty of perjury, and submit an application for medical assistance in accordance with rule 5160:1-2-01 of the Administrative Code. ~~The individual's signature may be written (original or a copy), electronic, or telephonic.~~

(b) Cooperate with the administrative agency in any eligibility determination for initial or continuing coverage, audit, and quality control process set out in this chapter of the Administrative Code. The individual must:

(i) In completing an application or renewal for medical assistance, answer all required questions and provide documentation requested by the administrative agency necessary to verify the conditions of eligibility as described in rule 5160:1-2-10 of the Administrative Code and any other relevant eligibility criteria required under Chapter 5160:1-3, 5160:1-4, 5160:1-5, or 5160:1-6 of the Administrative Code.

(ii) Request assistance from the administrative agency when unable to obtain requested information. The individual must provide the information necessary to allow the administrative agency to assist the individual.

(c) Select a managed care ~~plan~~ organization ~~(MCP)~~(MCO) as required by rule 5160-26-02 of the Administrative Code, unless the individual meets one of the exceptions listed in that rule.

(d) Inform the administrative agency within ten calendar days of any change to the following circumstances for the individual or any person living with the individual:

(i) ~~Address~~Contact information.

(a) Address; or

(b) Phone number; or

(c) Email address.

(ii) Marital status.

~~(ii)~~ (iii) Income, including any:

(a) One-time gifts or payments; or

~~(a)~~ (b) Change in hourly wage or salary; or

~~(b)~~ (c) Change in full-time or part-time status; or

~~(c)~~ (d) ~~Loss~~Gain or loss of employment.

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

~~(iv)~~ (v) Third-party responsibility for the individual's health care costs, including:

(a) New coverage under a health insurance policy, ~~no matter~~regardless of who is paying for the coverage; or

(b) A change in health insurers; or

(c) Loss or ending of other health insurance coverage; or

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

(e) Any accident or injury for which another person or entity may be responsible, such as a work-related injury or an injury received in an automobile collision. In addition to reporting the injury or accident, an individual must also report any information received about any involved insurance company.

(e) Cooperate with any third party responsible for an individual's health care costs.

(f) Not commit medicaid eligibility fraud as described in section 2913.401 of the Revised Code.

(2) When applying for or receiving medical assistance on the basis of being blind, disabled, or at least age sixty-five, an individual must also inform the administrative agency of any:

(a) Improvement of the condition for which the benefit is received; or

(b) Change in the ownership or value of a resource owned by the individual or the individual's spouse, including any change in an annuity or an annuity's remainder beneficiary designation.

(C) Authorized representative.

(1) An individual may designate an authorized representative, in writing, to stand in place of the individual and act with authority on behalf of the individual, as described in rule 5160-1-33 of the Administrative Code.

(2) ~~If~~ When an individual is unable to identify an authorized representative because of incapacity or incompetence, the administrative agency will assist the individual with appointing an authorized representative, as described in rule 5160:1-2-01 of the Administrative Code.

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5160:1-2-14 Medicaid: continuous eligibility for children younger than age nineteen.

(A) This rule describes the twelve-month period of continuous eligibility for a child younger than age nineteen, and the conditions under which the child's coverage ends during the twelve-month period, as described in section 1902(e)(12) of the Social Security Act (as in effect October 1, ~~2019~~2022).

(B) Eligibility criteria. A child remains eligible for coverage despite changes in the child's circumstances for a period of twelve months ~~if~~ when the child was found to be eligible for a category of medical assistance other than:

(1) Presumptive eligibility as described in ~~Chapter 5160:1-1 or Chapter 5160:1-2~~rule 5160:1-2-13 of the Administrative Code;

(2) ~~Alien~~Non-citizen emergency medical assistance as described in rule ~~5160:1-1-05 or~~ 5160:1-5-06 of the Administrative Code; or

(3) Refugee medical assistance as described in rule 5160:1-5-05 of the Administrative Code.

(C) Duration.

(1) A child's twelve-month period of continuous eligibility begins:

(a) On the date that medical assistance began as a result of an initial determination or annual renewal in accordance with rule 5160:1-2-01 ~~or rule 5160:1-2-01.2~~ of the Administrative Code~~,~~.

(b) ~~Without regard to any~~Any months of retroactive eligibility received by the child are not included in the twelve-month period of continuous eligibility.

(2) The child's coverage shall be terminated during the continuous eligibility period only:

(a) Upon oral or written request of the child (~~if~~ when the child is at least eighteen years old) or the child's representative; or

(b) When the child:

(i) No longer resides in the state of Ohio; or

(ii) Dies~~.~~; or

(iii) Has not paid the premium amounts required for coverage, when the child is covered under the medicaid buy-in for workers with disabilities category described in rule 5160:1-5-03 of the Administrative Code; or

(iv) Reaches the age of nineteen.

(D) ~~-~~Patient liability, or premium. A patient liability or premium calculated for a child in accordance with Chapters 5160:1-3 to 5160:1-6 of the Administrative Code shall not increase during the child's continuous coverage period. Any decrease in a child's patient liability or premium results in a new maximum amount, which will not increase for the remainder of the child's continuous coverage period.

(E) Regardless of a child's status under this rule, payment for services shall not be made ~~if~~ when payment is prohibited under rule ~~5160:1-1-05~~5160:1-1-03 of the Administrative Code.

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5160:1-3-02.2 Medicare buy-in.

(A) This rule sets forth:

(1) The eligibility criteria for benefits under the medicare part B (part B) buy-in agreement between the social security administration (SSA) and the Ohio department of medicaid (ODM), which allows ODM to pay ~~medicare~~ part B (supplemental medical insurance) premiums for certain ~~medicaid-eligible~~ individuals even ~~if~~ when those individuals are not eligible for a medicare premium assistance program (MPAP) set ~~out~~forth in rule 5160:1-3-02.1 of the Administrative Code; and

(2) The beginning date of payment of ~~medicare~~ part B ~~(part B)~~ benefits under this rule; and

(3) The date and effect of termination of benefits under ~~medicare~~ part B buy-in.

(4) The process of coordinating enrollment with ODM and the SSA.

(B) Definitions.

(1) "Medicare buy-in" means the program and process of paying part A and/or part B benefits on behalf of an eligible individual.

(2) "Part B buy-in" means the agreement under which ODM pays part B premiums on behalf of an eligible individual.

(C) Eligibility criteria. To be eligible for payment of the part B premium under the medicare buy-in agreement, an individual must meet all three of the following requirements:

(1) Be eligible for part B.

(2) Be eligible for a category of ~~medicaid~~ medical assistance other than:

(a) Breast and cervical cancer project ~~medicaid~~ as set forth in rules 5160:1-5-02 to 5160:1-5-02.4 of the ~~Adminstrative~~Administrative Code; or

(b) Presumptive ~~medicaid~~ eligibility as set forth in rule 5160:1-2-13 of the Administrative Code.

(3) Be receiving at least one of the following:

(a) Medicare premium assistance under rule 5160:1-3-02.1 of the Administrative Code.

(b) One of the following ~~kinds~~ types of cash assistance:

(i) Ohio works first (OWF); or

(ii) Supplemental security income (SSI); or

(iii) Residential state supplement.

(c) Four-month extended coverage as set forth in rule 5160:1-4-05 of the Administrative Code.

(d) ~~Grandfathered medicaid as~~Medical assistance under the grandfathering provisions set forth in rule

5160:1-3-02.6 of the Administrative Code.

(e) Foster care maintenance payments or adoption assistance payments as set forth in rule 5160:1-2-14 of the Administrative Code.

(f) ~~Medicaid~~ Medical assistance as a result of section 1619(b) of the Social Security Act (as in effect October 1, ~~2019~~2022) as set forth in rule ~~5160:1-3-02.8~~5160:1-3-02.5 of the Administrative Code.

(g) Deemed ~~OWF~~cash assistance ~~as described in 42 C.F.R 435.115 (as in effect October 1, 2019)~~under Pub.L.No. 94-48.

(h) Long-term care services in a Title XIX certified nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF-IID).

(i) Home and community-based ~~(HCB)~~ services (HCBS), including the program of ~~all inclusive~~ all-inclusive care for the elderly (PACE), under a waiver described in agency 5160 of the Administrative Code.

(D) Coordination of enrollment. ~~If~~ When an individual is eligible for benefits under this rule or would be eligible if the individual ~~were~~ was enrolled in part A or part B, the county department of job and family services (CDJFS) shall coordinate the individual's receipt of benefits. ~~If~~ When the individual:

(1) Is or has ever been in receipt of part A or part B benefits, the CDJFS shall approve part B buy-in benefits for the individual in the electronic eligibility system.

(2) Has never received part A or part B benefits, the CDJFS shall:

(a) Inform the individual that ~~the Ohio department of medicaid (ODM)~~ODM cannot pay medicare premiums until the individual has enrolled in part A or part B through the SSA; and

(b) Advise the individual to apply for part A or part B benefits, and advise the individual that the CDJFS will assist upon request; and

(c) Advise the individual to report the approval of part A or part B benefits to the CDJFS immediately, so payment of premiums can be approved; and

(d) Approve part B buy-in benefits for the individual in the electronic eligibility system upon being informed that the individual has been enrolled by the SSA in part A or part B.

(E) Coverage period.

(1) Start date.

(a) For MPAP benefits under rule 5160:1-3-02.1 of the Administrative Code, the beginning date for payment of premiums is addressed in those rules. ~~If~~ When an individual is eligible for MPAP benefits under rule 5160:1-3-02.1 of the Administrative Code and also eligible for part B buy-in under this rule, payment of part B premiums begins on the earlier of the coverage date under rule 5160:1-3-02.1 of the Administrative Code or the coverage date under this rule.

(b) For individuals eligible for payment of premiums under the part B buy-in agreement, eligibility begins:

(i) The first month an individual is eligible for both medicare and cash assistance as defined in paragraph (C)(3)(b) of this rule; or

(ii) The first day of the second month after the administrative agency made the determination the individual was eligible for ~~medicaid~~medical assistance, ~~if~~ when the individual is not in receipt of cash assistance as defined in paragraph (C)(3)(b) of this rule.

(2) Termination date. Eligibility for payment of medicare premiums under this rule ends on the ~~last day of the month in which the individual dies.~~earliest of the following dates:

(a) The last day of the month in which the individual dies; or

(b) The last day of the month in which the individual is entitled to part B benefits; or

(c) The last day of the last month in which the individual meets the eligibility criteria for part B buy-in benefits, when notice was provided to the centers for medicare and medicaid services (CMS) no later than the twenty-fifth day of the second month of ineligibility; or

(d) The last day of the second month before CMS received notice the individual was no longer eligible for part B buy-in benefits, when notice was not provided within the time limit identified in paragraph (E)(2)(c) of this rule.

(F) Retroactive termination. An individual's part B premium payment under buy-in can be terminated retroactively for as many as two months before the state's notice to CMS that the individual is no longer eligible.

(1) After CMS receives notice from ODM, CMS sends the individual a notice stating the individual is responsible for paying part B premiums beginning with the month following the last month of buy-in coverage. Because of administrative delays, an individual can already be in the third month after buy-in termination and owe three months of part B premiums before receiving notice that buy-in coverage has been terminated.

(2) The individual may request equitable relief from CMS under certain conditions specified by CMS in its notice.

DRAFT - NOT FOR FILING

5160:1-5-08 Medicaid: state-funded medical assistance for non-citizen victims of trafficking.

(A) This rule describes the eligibility requirements for state-funded medical assistance for a non-citizen victim of a severe form of human trafficking. ~~Eligibility for this program shall be determined for applications for medical assistance filed on or after the effective date of this rule.~~

(B) For purposes of this rule the following definitions apply unless otherwise stated.

(1) "Labor trafficking" means recruiting, harboring, transporting, or obtaining of a person for labor or services through the use of force, fraud, or intimidation for the purpose of involuntary servitude, debt bondage, or slavery.

(2) "Severe form of human trafficking" means sex trafficking or labor trafficking.

(3) "Sex trafficking" means recruiting, harboring, transporting, or obtaining of a person for the purpose of a commercial sex act where the commercial sex act is induced by force, fraud, or intimidation, or the person being induced to perform such act is under eighteen years of age.

(4) "T non-immigration status" is also known as the T Visa and provides immigration protection to victims of a severe form of human trafficking.

(C) Eligibility criteria.

(1) To be eligible for medical assistance, the non-citizen victim of a severe form of human trafficking must:

(a) Have applied for, or be in the process of preparing to file an application with the United States citizenship and immigration services (USCIS) for, "T" non-immigration status; and

(b) Be an Ohio resident as described in rule 5160:1-2-10 of the Administrative Code; and

(c) Meet the financial requirements described in paragraph (D) of this rule.

(2) An individual under this program is not required to provide a social security number.

(D) Financial eligibility.

(1) To have eligibility under this program, the individual must have countable monthly income at or below one hundred per cent of the federal poverty level (FPL) as determined in accordance with rules 5160:1-3-03.1 and 5160:1-3-03.2 of the Administrative Code. Only the individual's income is compared to the income standard. The FPL is adjusted annually.

(2) The deeming provisions set forth in rules 5160:1-3-03.1 and 5160:1-3-03.3 of the Administrative Code do not apply to the eligibility determination for a non-citizen victim of a severe form of human trafficking.

(E) Resource eligibility. There is no resource limit for individuals described in this rule.

(F) Retroactive eligibility. Eligibility for retroactive coverage of medical assistance shall be determined in accordance with rule 5160:1-2-01 of the Administrative Code.

(G) County department of job and family services (CDJFS) responsibilities. The CDJFS shall:

(1) Verify the individual has applied for, or is preparing to apply for, "T" non-immigration status with the

USCIS.

(a) The CDJFS must accept the following documentation when the individual claims to have already applied for a "T" non-immigration status:

(i) Form I-797, "Notice of Action", issued by the USCIS; or

(ii) Completed Form I-914, "Application for T Non-Immigration Status"; or

(iii) Completed Form I-914, Supplement B, "Declaration of Law Enforcement Officer for Victim of Trafficking in Persons"; or

(iv) Printouts of case status queries from the USCIS website; or

(v) Other correspondence from USCIS regarding applications, such as appointment notices.

(b) When the individual is preparing to file for "T" non-immigration status, the CDJFS shall:

(i) Verify with a sworn written statement that the individual is a victim of a severe form of human trafficking and at least one item of additional credible evidence, including but not limited to any of the following:

(a) Police, government agency, or court records or files; or

(b) News articles; or

(c) Documentation from a social services agency, domestic violence center, rape crisis center, or a legal, clinical, or medical professional, or other professional to whom the individual has reported the crime; or

(d) A written statement from any other individual with knowledge of the circumstances that provided the basis for the claim; or

(e) Physical evidence; or

(f) A written notice from the federal agency of receipt of the visa application.

(ii) Determine ~~if~~ whether the sworn statement is credible ~~if~~ when the individual is unable to provide any of the additional evidence listed in this rule.

(2) Determine the individual does not qualify for another category of medical assistance.

(H) Individual responsibilities. The individual shall:

(1) Cooperate with the CDJFS to determine financial eligibility for medical assistance.

(2) Cooperate with the CDJFS to determine non-financial eligibility for medical assistance.

(3) ~~Cooperate in providing~~Provide verification of any third-party liability or coverage of medical expenses as defined in rule 5160:1-2-10 of the Administrative Code.

(4) Cooperate with the child support enforcement agency (CSEA) in establishing the paternity of any medicaid eligible child and in obtaining medical support and payments as described in rule 5160:1-2-10

of the Administrative Code.

(5) Report changes within ten days to the CDJFS in accordance with rule 5160:1-2-08 of the Administrative Code. Changes include but are not limited to the following:

(a) Approval or denial of the application for "T" non-immigration status~~; and~~.

(b) Immigration status~~; and~~.

(c) ~~Address; and~~Contact information.

(i) Address; or

(ii) Phone number; or

(iii) Email address.

(d) Marital status~~; and~~.

(e) Income~~; and~~.

(f) Pregnancy status.

(6) File a formal application for "T" non-immigration status within one year of ~~his or her date of~~the application date for medical assistance~~,~~. When the individual fails to file a formal application, eligibility for medical assistance will be discontinued, unless it can be determined that during the year the individual:

(a) Experienced a health crisis; or

(b) Has been unable, after reasonable attempts, to obtain the necessary information from a third party; or

(c) Has other extenuating circumstances that prevented the individual from completing his or her application.

(I) There is not a limitation on the amount of time the individual can receive coverage under this medical assistance category, provided the individual continues to meet all relevant eligibility criteria.