# Ohio Administrative Code

## Rule 5160:1-2-13 Medicaid: presumptive eligibility.

Effective: September 1, 2023

(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 when 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 household composition will be determined, comprised of the individual and, if living in the home:

(i) The individual's spouse; and

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

(iii) When 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 the individual is eligible or ineligible for ongoing medical assistance pursuant to rule 5160:1-2-01 of the Administrative Code; or

(b) When 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) 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) is responsible for training and monitoring each qualified entity (QE) in accordance with rule 5160-1-17.12 of the Administrative Code.

(E) QE responsibilities.

(1) When the QE is a county department of job and family services (CDJFS) office:

(a) No later than twenty-four hours after receipt of a signed and dated full application for medical assistance on behalf of an individual, the CDJFS must determine, based on the individual's self-declared information, whether the individual is eligible for presumptive coverage under this rule.

(b) When an individual is eligible for presumptive coverage, the CDJFS must:

(i) Approve presumptive coverage for the individual; and

(ii) Provide a notice issued from the electronic eligibility system to inform the individual:

(A) That presumptive coverage was approved; 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 discontinuance of presumptive coverage.

(c) When an individual is not eligible for presumptive coverage, the CDJFS must inform the individual that eligibility for medical assistance will be determined within forty-five days.

(d) Whether or not an individual is eligible for presumptive coverage, 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) When the QE is a hospital, the Ohio department of rehabilitation and correction (DRC), the Ohio department of youth services (DYS), a federally qualified health center (FQHC), an FQHC look-alike, a local health department, a special supplemental nutrition program for women, infants, and children (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, determine whether the individual is presumptively eligible under this rule. Such determination shall not be delegated to a third party, but shall be completed by the QE.

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

(c) When the individual is presumptively eligible:

(i) Approve presumptive coverage for the individual using the electronic eligibility system designated by ODM ; and

(ii) Provide a notice issued from the electronic eligibility system to the individual at the time of determination which indicates that presumptive coverage was approved and which includes:

(A) The presumptive eligibility determination date; and

(B) The basis for presumptive eligibility; and

(C) The individual's name, date of birth, and address; and

(D) The individual's medicaid  billing number; and

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

(iii) Upon request, assist the individual with completing an application for ongoing medical assistance.

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

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