Ohio Administrative Code

Rule 5160:1-1-01 Medicaid: definitions.

Effective: January 1, 2023

(A) This rule contains definitions generally used in determining eligibility for medical assistance.

(B) Definitions.

(1) "Abuse" means any action by an individual or entity that results in unnecessary costs to the medical assistance program in accordance with 42 C.F.R 455.2 (as in effect October 1, 2022).

(2) "Administrative agency" means the Ohio department of medicaid (ODM) and/or an agent of ODM authorized to determine eligibility for a medical assistance program.

(3) "Advance notice of adverse action" means a written notice of the administrative agency's intent to discontinue or suspend medical assistance, reduce the level of benefits or covered services, or increase the amount of an individual's premium or patient liability, sent no less than fifteen calendar days prior to the date of the proposed action in accordance with rules 5101:6-2-04 and 5101:6-2-05 of the Administrative Code.

(4) "Applicant" means an individual who is seeking an eligibility determination for himself or herself through an application submission or a transfer from another agency or insurance affordability program in accordance with 42 C.F.R. 435.4 (as in effect October 1, 2022).

(5) "Approve" or "approval" means a determination by the administrative agency that an individual is eligible for one or more categories of medical assistance applied for by the individual or on behalf of the individual by his or her authorized representative.

(6) "Assets" means all income and resources of the individual and of the individual's spouse. This includes any income or resources the individual or the individual's spouse is entitled to, but does not receive, because of an action taken to avoid receipt of the asset by:

(a) The individual or the individual's spouse; or

(b) A person, including a court or administrative body, with legal authority to act in place of, or on behalf of, the individual or the individual's spouse; or

(c) Any person, including any court or administrative body, acting at the direction, or upon the request, of the individual or the individual's spouse.

(7) "Assignment" means an individual eligible for medical assistance has transferred his or her right, or the rights of any other individual for whom he or she can legally make an assignment, to collect and retain third-party and/or medical support payments to ODM up to the amount of medical services paid under the medicaid program.

(8) "Authorized representative" means a person, who is at least eighteen years of age, or a legal entity who stands in place of the individual. Actions or failures of an authorized representative will be accepted as the action or failure of the individual. When an individual has designated an authorized representative, all references to the individual's responsibilities include the authorized representative in accordance with rule 5160-1-33 of the Administrative Code.

(9) "Base eligibility" means the individual meets all of the eligibility requirements for at least one category of medical assistance described in Chapter 5160:1-3, 5160:1-4, or 5160:1-5 of the Administrative Code.

(10) "Caretaker relative" means a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care (as may, but is not required to, be indicated by claiming the child as a tax dependent for federal income tax purposes), and who is one of the following:

(a) The child's father, mother, brother, sister, stepfather, stepmother, stepbrother, or stepsister; or

(b) The child's grandfather, grandmother, uncle, aunt, nephew, or niece, including such relatives with the prefix great, great-great, grand, or great-grand; or

(c) The child's first cousin or first cousin once removed; or

(d) The spouse of such parent or relative, even after the marriage is terminated by death or divorce.

(11) "Case record" means electronic or paper documents and information used to determine, redetermine, or renew an individual's eligibility for medical assistance.

(12) "Creditable insurance" or "creditable coverage" means health insurance coverage as defined in 42 U.S.C. 300gg-3(c) (as in effect October 1, 2022).

(a) This includes:

(i) A group health plan; or

(ii) Health insurance coverage; or

(iii) Medicare part A, as set forth in 42 U.S.C. 1395c to 1395i-5 (as in effect October 1, 2022) or part B, as set forth in 42 U.S.C. 1395j to 1395w-6 (as in effect October 1, 2022); or

(iv) Coverage under medicaid, as set forth in Title XIX of the Social Security Act, other than coverage consisting solely of benefits under the pediatric vaccine program set forth in 42 U.S.C. 1396s (as in effect October 1, 2022); or

(v) Armed forces health insurance as set forth in 10 U.S.C. 1071 to 1110b (as in effect October 1, 2022); or

(vi) A medical care program of the Indian health service or of a tribal organization; or

(vii) A state health benefits risk pool; or

(viii) A federal employee health plan offered under 5 U.S.C. 8901 to 8992 (as in effect October 1, 2022); or

(ix) A public health plan; or

(x) A peace corps volunteer health benefit plan under section 22 U.S.C. 2504 (as in effect October 1, 2022).

(b) Creditable insurance does not include:

(i) Coverage only for accident or disability income insurance; or

(ii) Liability insurance, including general liability insurance and automobile liability insurance, or coverage issued as a supplement to liability insurance; or

(iii) Workers' compensation or similar insurance; or

(iv) Automobile medical payment insurance; or

(v) Credit insurance which pays off existing debts in the event of death, disability, or unemployment; or

(vi) Coverage for employment onsite medical clinics; or

(vii) Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits; or

(viii) Limited-scope dental or vision benefits; or

(ix) Benefits for long-term care, nursing facility care, home health care, or community-based care; or

(x) Coverage only for a specified disease or illness; or

(xi) Hospital indemnity or other fixed indemnity insurance, if purchased separately; or

(xii) Medicare supplemental health insurance as defined under 42 U.S.C. 1395ss (as in effect

October 1, 2022), coverage supplemental to the coverage provided to military or former military personnel under 10 U.S.C. 1071 to 1110b (as in effect October 1, 2022), and similar supplemental coverage provided to coverage under a group health plan; or

(xiii) Coverage through a medical cost-sharing program, including a health care cost-sharing ministry.

(13) "Deduction" means a verifiable amount the individual pays for an expense. Garnishments or liens placed against earned or unearned income of an individual are not considered a deduction, regardless of the reason for the garnishment or lien.

(14) "Deny" or "denial" means a determination by the administrative agency that an individual is not eligible for one or more categories of medical assistance applied for by the individual or on behalf of the individual by his or her authorized representative.

(15) "Dependent child" means a person younger than age eighteen living with a parent or caretaker relative.

(16) "Discontinue" or "discontinuance" means a determination by the administrative agency that an individual is no longer eligible, or has failed to cooperate with verification of eligibility, for one or more categories of medical assistance currently being received by that individual, resulting in a written notice of the administrative agency's intention to end coverage under that category and providing notice of hearing rights in accordance with 42 C.F.R. 435.917 (as in effect October 1, 2022).

(17) "Disregard" means the amount subtracted from gross, non-excluded income in the medical assistance budget calculation.

(18) "Early and periodic screening, diagnostic and treatment" (EPSDT) means screening, vision, dental, and hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in 42 U.S.C. 1396d (as in effect October 1, 2022) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the medicaid state plan. Healthchek is Ohio's EPSDT

program.

(19) "Earned income" means income in cash or in-kind received as payment for services performed as an employee or as a self-employed individual. Earned income includes but is not limited to wages, salary, or commissions from which state or federal income taxes are paid or withheld.

(20) "Electronic equivalent" means an electronic version of an Ohio department of job family services (ODJFS) or ODM form or application which has not been modified in any way, other than format, prior to completion and submission of that form to the administrative agency. The administrative agency is not required to accept forms that are altered.

(21) "Electronic protected health information" (ePHI) means any protected health information (PHI) that is maintained or transmitted in electronic form, regardless of the format.

(22) "Electronic signature" means an electronic sound, symbol, or process attached to, or logically associated with, a record and executed or adopted by a person with the intent to sign the record as defined in section 1306.01 of the Revised Code.

(23) "Encumbrance" means a claim, lien, charge, or liability attached to and binding on an identified piece of real or personal property.

(24) "Equity value" means the fair market value of a resource minus any encumbrance.

(25) "Erroneous payment" means a medicaid reimbursement made for an individual who was ineligible at the time services were received, regardless of the presence of fraud or abuse.

(26) "Excluded income" means income that state or federal law prohibits from consideration in determining eligibility for medical assistance.

(27) "Fair market value" means, unless otherwise stated, the going price, at the time of the transfer or contract of sale, for which real or personal property can reasonably be expected to sell on the open market in the relevant geographic area. The appraised value of real property is determined by the county auditor and may be used to establish fair market value.

(28) "Family size" means the number of persons counted as members of an individual's medicaid household.

(29) "Federal adoption assistance" (AA) means the Title IV-E subsidy program as defined by the Adoption Assistance and Child Welfare Act of 1980 (Pub. L. No. 96-272).

(30) "Federal benefit rate" (FBR) means the supplemental security income (SSI) current payment standard published annually by the social security administration (SSA).

(31) "Federal foster care maintenance" (FCM) means the Title IV-E program, as described in rule 5101:2-47-01 of the Administrative Code.

(32) "Federal kinship guardianship assistance program" (KGAP) means the Title IV-E program to provide payments to relatives, as defined in section 5101.141 of the Revised Code, who have assumed legal custody or guardianship of eligible children whom they have cared for as foster parents for a minimum of six consecutive months and for whom there is a valid KGAP or KGAP C21 agreement.

(33) "Federal means-tested public benefit" means a benefit in which eligibility for the benefit or the amount of the benefit, or both, is determined on the basis of income or resources of the individual seeking the benefit. Medicaid, cash assistance, and food assistance are federal means-tested public benefits, but certain other benefits listed in 8 U.S.C. 1613(c) (as in effect October 1, 2022) are not considered means-tested.

(34) "Federal poverty level" (FPL) means a measure of income determined annually by the department of health and human services (HHS). The FPL is designed to provide a baseline for determining financial eligibility for federal programs and benefits.

(35) "Good cause" means circumstances that reasonably prevent an individual from cooperating with the administrative agency in the eligibility determination process. Factors relevant to good cause include, but are not limited to, natural disasters, riots or civil unrest, death or serious illness of the individual or a member of his/her immediate family, or the physical, mental, educational, or

linguistic limitations of the individual.

(36) "Gross income" means income prior to any deductions or disregards, with the exception of self-employment gross countable income.

(37) "Health Insurance Portability and Accountability Act of 1996" (HIPAA) means a federal law to protect patient privacy, to protect security of electronic medical records, to prescribe methods and formats for exchange of electronic medical information, and to uniformly identify providers.

(38) "Immigrant" means a person who comes to the United States (U.S.) with plans to live in the country permanently. This term includes, but is not limited to, an individual who is a refugee, asylee, parolee, or other entrant regardless of whether he or she is residing in the U.S. legally.

(39) "Income" means cash, in-kind income as defined in paragraph (B)(43) of this rule, or something of value which is received, available, and attributable to an individual. Income includes the receipt of any item which can be applied, either directly or by sale or conversion, to meet the needs of an individual.

(40) "Income and eligibility verification system" (IEVS) means the electronic system that shares income and asset information among the social security administration (SSA), internal revenue service (IRS), state wage information collection agency (SWICA), agencies administering unemployment compensation (UC) benefits, and the administrative agency.

(41) "Individual" means a person applying for or receiving medical assistance.

(42) "Individually identifiable health information" means information that is a subset of health information that includes demographic information collected from an individual and:

(a) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

(b) Relates to the past, present, or future physical condition or mental health condition of an individual, the provision of health care to an individual, or the past, present, or future payment for

the provision of health care to an individual and either:

(i) Identifies the individual; or

(ii) There is a reasonable basis to believe the information can be used to identify the individual.

(43) "In-kind income" means any benefit received other than cash such as food, shelter, or something that can be used to get food or shelter.

(44) "Institution for mental diseases" (IMD) means a hospital, nursing facility, or other institution of more than sixteen beds which primarily provides diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

(a) A facility is an IMD, whether or not it is licensed as such, if it is operated primarily for the care and treatment of individuals with mental diseases.

(b) An institution for persons with cognitive impairments or other developmental disabilities is not an IMD.

(45) "Lawfully residing" means a qualified non-citizen immigration status granted to an individual allowing him or her to live and/or work in the United States.

(46) "Legal custodian" means a person who has legal rights to have physical care and control of a child, as defined in section 2151.011 of the Revised Code.

(47) "Legal guardian" means any person, association, or corporation appointed by a probate court to exercise care and management of an individual, his or her estate, or both, as defined in section 2111.01 of the Revised Code.

(48) "Limited English proficiency" (LEP) means the inability of any person or group of persons to speak, read, write, or understand the English language at a level that allows them to meaningfully communicate with the administrative agency.

(49) "Liquid resource" means cash or property immediately convertible to cash.

(50) "Lump-sum" means a non-recurring payment received in a single amount, as opposed to smaller payments over time.

(51) "Managed care organization" (MCO) has the same meaning as in rule 5160-26-01 of the Administrative Code.

(52) "Medicaid buy-in for workers with disabilities" (MBIWD) as set forth in rule 5160:1-5-03 of the Administrative Code, is a category of medical assistance that enables workers with disabilities to earn income and have resources, not to exceed the limits established by the state, without the risk of losing health care coverage.

(53) "Medicaid eligibility fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to himself, herself, or some other person in accordance with 42 C.F.R. 455.2 (as in effect October 1, 2022). It includes any act that constitutes fraud under applicable federal or state law.

(54) "Medicaid household" means a group of individuals, defined in relationship to one specific medical assistance applicant or recipient, who impact the applicant's or recipient's family size, household income, or both.

(55) "Medical assistance" includes all programs administered by the state medicaid administrative agency.

(56) "Medical support" means an order by a court to provide medical coverage.

(57) "Medical verification of pregnancy" means a written statement signed by a licensed medical professional verifying pregnancy and includes the expected date of delivery and, if more than one, the expected number of fetuses.

(58) "Minor child" means a person younger than age eighteen.

(59) "Modified adjusted gross income" (MAGI or MAGI-based income) means the income methodology used for determining medical assistance eligibility for children through age eighteen, parents, caretaker relatives, pregnant women, and adults age nineteen through sixty-four.

(60) "Non-applicant" means a person who is not seeking an eligibility determination for himself or herself but is included in an applicant's or recipient's medicaid household to determine eligibility for such applicant or recipient.

(61) "Non-citizen emergency medical assistance" (NCEMA) as established in rule 5160:1-5-06 of the Administrative Code, means time-limited coverage of an emergency medical condition for certain individuals who do not meet the citizenship or satisfactory immigration status requirements.

(62) "Non-cooperation" or "failure to cooperate" means failure by an individual to present required verification, or to explain why it is not possible to present the verification, after being notified the verification was required for eligibility determination.

(63) "Non-excluded income" means income (earned or unearned) that is used in the eligibility determination for medical assistance.

(64) "Outstationing" means the federal requirement as described in 42 C.F.R. 435.904 (as in effect October 1, 2022) that administrative agencies provide opportunities for low-income pregnant women and children to apply for medical assistance at locations other than the local county department of job and family services.

(65) "Parent" means a natural, adoptive, or step-parent.

(66) "Personal property" means any property that is not real property, as defined in paragraph (B)(75) of this rule. Personal property includes, but is not limited to, such things as cash, jewelry, household goods, tools, life insurance policies, automobiles, and promissory notes.

(67) "Postpartum period" means the maximum permitted period of coverage as described in 42 U.S.C. 1396a(e) (as in effect October 1, 2022).

(68) "Pre-termination review" (PTR) means a review of eligibility criteria completed prior to each discontinuance of medical assistance, to determine whether an individual is eligible for any other category of medical assistance in accordance with 42 C.F.R. 435.916(f)(1) (as in effect October 1, 2022). Home and community-based services (HCBS), as defined in rule 5160:1-6-01.1 of the Administrative Code, the specialized recovery services (SRS) program described in rule 5160:1-5-07 of the Administrative Code, or both will be explored as part of the PTR process when:

(a) The individual or his or her authorized representative has requested HCBS or SRS; or

(b) The individual's case record contains information indicating that he or she may be eligible for or in need of HCBS or SRS. Receipt of SSI, social security disability insurance (SSDI), or any other income type resulting from an individual's disability is not sufficient, by itself, to demonstrate potential eligibility for or need of HCBS or SRS. There must be additional factors in the case record that indicate the individual's potential eligibility for or need of HCBS or SRS.

(69) "Private child placing agency" (PCPA) means any association that is certified to accept temporary, permanent, or legal custody of children and place the children for foster care or adoption, as defined in rule 5101:2-1-01 of the Administrative Code.

(70) "Protected health information" (PHI) means individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

(71) "Public children services agency" (PCSA) means an entity that has assumed the powers and duties of the children services function for a county, as defined in rule 5101:2-1-01 of the Administrative Code.

(72) "Public institution" means an institution, as defined in 42 C.F.R. 435.1010 (as in effect October 1, 2022), that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control, such as a state or federal prison, local jail, detention facility, or other penal setting. Public institution does not include a medical institution, an intermediate care facility, a publicly operated community residence that serves no more than sixteen residents, or a child care institution.

(73) "Qualified entity" means the source of eligibility determinations for the presumptive eligibility program and is limited to the following:

(a) A county department of job and family services (CDJFS); or

(b) A hospital, the Ohio department of rehabilitation and correction (DRC), or the Ohio department of youth services (DYS); or

(c) A federally qualified health center (FQHC) or an FQHC look-alike that meets the requirements described in Chapter 5160-28 of the Administrative Code; or

(d) A local health department, a special supplemental nutrition program for women, infants, and children (WIC) clinic, or other entity as designated by the director.

(74) "Recipient" means an individual who has been determined eligible and is currently receiving medical assistance in accordance with 42 C.F.R. 435 (as in effect October 1, 2022).

(75) "Real property" means land, including buildings or immovable objects attached permanently to the land.

(76) "Refugee" means a person who flees his or her country due to persecution or a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group and is admitted to the United States under Section 207 of the Immigration and Nationality Act (INA), 8 U.S.C. 1157 (as in effect October 1, 2022).

(77) "Redetermination" means acting upon new or changed information received after an individual's eligibility has been determined but prior to the regularly scheduled annual renewal.

(a) The administrative agency shall only redetermine eligibility using the new or changed information. All other factors of eligibility not affected by the new or changed information are presumed unchanged.

(b) The original renewal date is not changed when eligibility has been redetermined, unless the administrative agency has sufficient information regarding all eligibility factors to renew eligibility without requesting additional information from the individual.

(78) "Renew" or "renewal" means a review of eligibility factors to determine whether the individual continues to meet all of the criteria of a medical assistance category. A renewal is performed annually.

(79) "Reporting" means notifying the administrative agency of any changes that may affect an individual's eligibility for medical assistance. Reporting changes and providing verifications is the responsibility of any individual, person, or entity who has a legal or financial responsibility for, or who stands in the place of, an individual, including:

(a) The individual; and

(b) The individual's spouse, including a community spouse; and

(c) The individual's parent, legal custodian, legal guardian, or caretaker relative; and

(d) The individual's authorized representative.

(80) "Residence" means the place the individual considers his or her established or principal home and to which, if absent, he or she intends to return.

(81) "Residential care facility" (RCF) means a home that provides either of the following as described in section 3721.01 of the Revised Code:

(a) Accommodations for seventeen or more unrelated individuals and supervision and personal care services for three or more of those individuals who are dependent on the services of others by reason of age or physical or mental impairment; or

(b) Accommodations for three or more unrelated individuals, supervision and personal care services for at least three of those individuals who are dependent on the services of others by reason of age or

physical or mental impairment, and, to at least one of those individuals, any of the skilled nursing care authorized by section 3721.011 of the Revised Code.

(82) "Resources" means cash, funds held within a financial institution, investments, personal property, and real property an individual and/or the individual's spouse has an ownership interest in, has the legal ability to access in order to convert to cash, and is not legally prohibited from using for support and maintenance.

(83) "Safeguarding" means security measures taken to ensure that the information of individuals applying for or receiving medical assistance is protected against unauthorized inspection, disclosure, or use. Safeguarding also refers to the restriction on the use, or disclosure, of individual information including federal tax information (FTI), any protected health information (PHI), or other confidential information used in the administration of the medicaid program in accordance with rule 5160-1-32 of the Administrative Code.

(84) "Self-attestation" or "self-declaration" means a statement of factual information made by an individual.

(85) "Self-Employment gross countable income" means the income from a business minus the expenses directly related to producing the goods or services, and without which the goods or services could not be produced.

(a) When the individual has filed taxes for the previous year, use all tax forms that were filed with the internal revenue service (IRS) to determine his or her self-employment gross countable income.

(b) When the individual has not filed taxes for the previous year, the following may be used to determine his or her self-employment gross countable income:

(i) Business records including receipts for the costs of doing business; or

(ii) Estimate of anticipated income and expenses.

(86) "Spouse" means a person who is legally married to another under Ohio law.

(87) "State adoption assistance" means the state-only adoption subsidy program as described in rule 5101:2-44-03 of the Administrative Code.

(88) "State foster care maintenance" means an entitlement for financial assistance for state-only foster care services as described in Chapter 5101:2-7 of the Administrative Code.

(89) "Support Services" means non-medical services offered or provided by the administrative agency to assist the individual and may include arranging or providing transportation, making medical appointments, accompanying the individual to medical appointments, and making referrals to community and other social services to be coordinated with the individual's medicaid-contracted managed care organization (MCO), where applicable.

(90) "Suspend" or "suspended" means the temporary discontinuance of eligibility.

(91) "Temporary absence" means that an individual is considered not to have changed residence and intends to return.

(a) An individual is considered to be temporarily absent with no time limit when all of the following conditions are met:

(i) The location of the absent individual is known; and

(ii) There is a definite plan for the return of the absent individual to the residence; and

(iii) The absent individual lived in the residence immediately prior to the absence, except for individuals described in paragraph (C)(1)(h) of rule 5160:1-4-02 of the Administrative Code.

(b) Child(ren) removed by the PCSA are considered temporarily absent as long as the reunification requirements specified in the reunification plan are met.

(92) "Terminate" or "terminated" has the same meaning as "discontinue" or "discontinuance" as defined in paragraph (B)(16) of this rule.

(93) "Unearned income" means all income that is not earned income as defined in paragraph (B)(19) of this rule.

(94) "United States (U.S.)" and "state(s)" mean all fifty U.S. states, the District of Columbia, and the U.S. territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, Swain's Island, and the U.S. Virgin Islands.

(95) "United States citizen or national" means any individual who is:

(a) A citizen or national through birth or collective naturalization as set forth in 8 U.S.C. Chapter 12, Subchapter III, Part I (as in effect October 1, 2022); or

(b) A naturalized citizen or national as set forth in 8 U.S.C. Chapter 12, Subchapter III, Part II (as in effect October 1, 2022).

(96) "Verification" means a document, statement, electronic validation, or other type of information provided by an individual or by a third party to confirm statements made by the individual regarding any requirement for eligibility for medical assistance. A verification document or written statement may be an original, photocopy, facsimile (fax), or electronic version of the original, unless otherwise stated.