Ohio | Department of Medicaid

John R. Kasich, Governor
John B. McCarthy, Director

MEDICAID ELIGIBILITY MANUAL TRANSMITTAL LETTER NO. 112

To: **All Medicaid Eligibility Manual Holders**

From: **John B. McCarthy, Director**

Subject: **Medicare Premium Assistance Programs (MPAP) and Income Standards**

Section 119.032 of the Revised Code requires the review of all state agency rules within a five-year period. The purpose of this review is to determine whether a rule:

1. Should continue without amendment, be amended or rescinded, taking into consideration the purpose, scope and intent of the statute under which the rule was adopted;
2. Should give more flexibility at the local level or eliminate unnecessary paperwork; and
3. Duplicates, overlaps with or conflicts with other rules.

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.

Chapter 3 Medicaid for the Aged Blind or Disabled

5160:1-3-02.1 Medicare Premium Assistance Programs (MPAP)

This rule is rescinded and the language is found in new OAC rule 5160:1-3-02.1 as part of a five-year rule review.

5160:1-3-02.1 Medicare Premium Assistance Programs (MPAP)

This rule replaces current rule 5160:1-3-02.1. Pursuant to Wheaton v. McCarthy, (6th Cir. 2015), changes to the rule include the addition of the definition of "family" to clarify that for MPAP eligibility, countable income will be compared to the appropriate income standard, which is the specified Federal Poverty Level (FPL) for the number of applicable family members residing in the household of an eligible MPAP individual or couple. Changes also include incorporating the definition of "QDWI" (which is an MPAP program) and the “QDWI” rule 5160:1-3-02.2 into rule 5160:1-3-02.1. Applicable income standards to qualify for the MPAP programs are now included in rule 5160:1-3-02.1. References to rule numbers have also been updated.

5160:1-3-02.2 Medicare: qualified disabled and working individuals (QDWI)

This rule is rescinded and the language is found in new OAC rule 5160:1-3-02.1 as part of a five-

year rule review.

5160:1-3-02.6 Medicare buy-in
This rule is rescinded and the language is found in new OAC rule 5160:1-3-02.2 as part of a five-year rule review.

5160:1-3-02.2 Medicare buy-in
This rule replaces current rule 5160:1-3-02.6. Changes to the rule include removing requirements applicable to MPAP from this rule to the MPAP rule 5160:1-3-02.1 of OAC, updating rule references, and assigning a new rule number.

5160:1-3-03.5 Medicaid: Need Standards
This rule is rescinded and the language is found in new OAC rule 5160:1-3-03.5 as part of a five-year rule review.

5160:1-3-03.5 Medicaid: Income Standards
This rule replaces current rule 5160:1-3-03.5. Changes to the rule include updating the term "need standards" to read "income standards" and moving the MPAP income standards from this rule to the MPAP rule 5160:1-3-02.1 of OAC. The rule title and references to rule numbers have also been updated.

ODM Form 07212: Explanation of Qualified Medicare Beneficiary (QMB)
This form is being obsoleted as it contains outdated references to spenddown. Information regarding all MPAP programs can be found on the MPAP Fact Sheet and the MPAP Information Card. These documents are accessible at:
http://medicaid.ohio.gov/FOROHIOANS/Programs/MPAP.aspx.

Fiscal Impact
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 ODJFS. Clarification regarding these rules will be available to county staff through the Medicaid Eligibility Technical Assistance staff, who can be reached via email at Medicaid_eligibility_ta@medicaid.ohio.gov .

MEMTL #112

TO BE RESCINDED

5160:1-3-02.1 Medicare premium assistance programs (MPAP).

(A) This rule sets forth the eligibility criteria and benefits for the medicare premium assistance programs (MPAP). These programs are: qualified medicare beneficiary (QMB), specified low-income medicare beneficiary (SLMB), and qualified individuals (QI-1).

(B) Definitions.

(1) "Enrolled," for the purpose of this rule, means an individual is in receipt of benefits under a medicare health plan.

(2) "MPAP" means any or all of the medicare premium assistance programs: QMB, SLMB, and QI-1.

(3) "MPAP resource limit" means the maximum amount of resources allowed under section 1905(p)(1) of the Social Security Act (as in effect on December 1, 2013), as adjusted annually according to the change in the consumer price index for urban areas.

(4) "Qualified," for the purpose of this rule, means an individual is eligible to receive benefits under a medicare health plan, whether or not the individual has applied for those benefits.

(5) "QI-1" means the qualified individual group, for which federal funds are provided each year, described in section 1902(a)(10)(E)(iv) of the Social Security Act (as in effect on December 1, 2013). Enrollment for this group may be limited.

(6) "QMB" means the qualified medicare beneficiary group described in section 1905(p)(1) of the Social Security Act (as in effect on December 1, 2013).

(7) "SLMB" means the specified low-income medicare beneficiary group described in section 1902(a)(10)(E)(iii) of the Social Security Act (as in effect on December 1, 2013).

(C) Eligibility. To be eligible for a medicare premium assistance program, an individual must meet all of the following conditions:

(1) Be qualified for coverage under medicare part A (part A).

(a) An individual is ineligible for MPAP benefits under this rule if the individual is receiving medicare benefits as described in paragraph (C) of rule 5160:1-3-02.2 of the Administrative Code, but may be eligible for benefits under rule 5160:1-3-02.2 or 5160:1-5-03 of the Administrative Code.

(b) An individual otherwise qualified for QMB must be enrolled in either part A or medicare part B (part B) for the administrative agency to provide benefits under this rule.

(c) An individual otherwise qualified for SLMB or QI-1 must be enrolled in part A for the administrative agency to provide benefits under this rule.

(2) Have resources, as determined under Chapter 5160:1-3 of the Administrative Code, no greater than the MPAP resource limit as defined in paragraph (B)(3) of this rule for an individual or for a couple, whichever is appropriate.

(3) Have income, as determined under paragraph (D) of this rule, within the MPAP need standards as set forth in rule 5160:1-3-03.5 of the Administrative Code.

(4) For QI-1, be otherwise ineligible for medical assistance under Chapters 5160:1-1 to 5160:1-5 of the Administrative Code, except that an individual who is eligible only with a delayed spenddown, as set forth in rule 5160:1-3-04.1 of the Administrative Code, can be eligible for QI-1 benefits.

(5) Meet the application, conditions of eligibility, and verification requirements set forth in Chapter 5160:1-2 of the Administrative Code.

(D) Countable income shall be determined under Chapter 5160:1-3 of the Administrative Code, except the annual cost of living increase (COLA) shall be deducted from the individual's income beginning in January of each year and continuing through the end of the month after the month in which the updated federal poverty guidelines are published in the Federal Register.

(E) Coverage periods.

(1) The effective date of QMB coverage is the first day of the month after the month in which the administrative agency approves QMB benefits. No retroactive coverage is available for QMB.

(2) Eligibility for SLMB benefits begins no earlier than the third month prior to the month of application, provided the individual met all eligibility criteria including enrollment in part A during the three-month period.

(3) QI-1 eligibility is limited by calendar year.

(a) QI-1 coverage begins on the first day of the month of application. If all eligibility requirements were met in any of the three months before the month of application, coverage begins three months before the month of application, except that retroactive coverage under QI-1 cannot begin earlier than January of the year of application.

(i) The individual must reapply for QI-1 coverage each year.

(ii) Federal funding is limited, and only a certain number of individuals can be covered. Applications are considered and individuals are approved for coverage on a first-come, first-served basis each year until the number of covered individuals equals that year's maximum.

(b) QI-1 coverage ends on December thirty-first of each year because, by federal statute, authorization for the program ends on December thirty-first each year unless Congress reauthorizes it.

(c) QI-1 coverage will end prior to December thirty-first if the individual dies or ceases to be an Ohio resident. In that case, coverage will end on the last day of the month in which either of those events occurs.

(4) The date and effect of termination of MPAP benefits is set forth in rule 5160:1-3-02.6 of the Administrative Code.

(F) Benefits.

(1) If an individual is eligible for QMB, the administrative agency shall pay the individual's:

(a) Premiums for part B and, if a premium is charged, part A; and

(b) Medicare deductibles; and

(c) Medicare co-pays; and

(d) Medicare coinsurance costs.

(2) If an individual is eligible for SLMB or QI-1, the administrative agency shall pay the individual's part B premiums.

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

(1) Explore eligibility for medicaid and for all MPAP categories if a medicaid applicant is qualified for part A. The agency shall advise the individual:

(a) Of the categories of medicaid or MPAP for which the individual is eligible, the individual's right to decline payment of premiums, co-pays, or coinsurance costs, and the effect of declining MPAP payments; and

(b) That if an individual is qualified for benefits under part A or part B, whether or not a premium would be charged for those benefits, the Ohio department of medicaid (ODM) is prohibited from paying for prescriptions on behalf of that individual.

(2) If an individual is eligible for QMB:

(a) Approve benefits under QMB and pay the part A, if applicable, and part B premiums on behalf of a QMB-eligible individual as set forth in rule 5160:1-3-02.6 of the Administrative Code, effective the month after the administrative agency approves QMB coverage; and

(b) Provide form ODM 07212 "Explanation of Qualified Medicare Beneficiary (QMB) Medicaid Coverage" (rev. 7/2014) to the individual; and

(c) For individuals who are not receiving free part A, but who could receive part A benefits by paying a premium, coordinate enrollment in parts A and B with ODM and the social security administration (SSA).

(3) If the individual is eligible for SLMB, approve benefits under SLMB and pay the individual's part B premium as set forth in rule 5160:1-3-02.6 of the Administrative Code, effective the month SLMB coverage begins.

(4) If an individual is determined to be eligible for QI-1:

(a) Approve QI-1 for eligible individuals on a first-come, first-served basis each year; and

(b) Pay the individual's part B premium as set forth in rule 5160:1-3-02.6 of the Administrative Code, effective the month QI-1 coverage begins.

(5) Determine whether coverage for any category of benefits under this rule should have been effective prior to the effective date in the electronic medicare buy-in system. If coverage should have begun earlier, the CDJFS shall request that ODM manually buy-in the individual with the correct coverage effective date.

(6) Deny benefits under this rule if:

(a) Any of the conditions for denial set forth in rule 5160:1-2-01 of the Administrative Code are met; or

(b) The individual is eligible only for benefits under QI-1 and there is insufficient funding for the QI-1 program.

(7) Terminate benefits under this rule if:

(a) An individual no longer meets the eligibility criteria for any covered group under this rule; or

(b) Any of the conditions for termination set forth in rule 5160:1-2-01 of the Administrative Code are met; or

(c) The individual was eligible for benefits under QI-1 but becomes eligible for another category of medicaid, including ongoing spenddown medicaid as set forth in rule 5160:1-3-04.1 of the Administrative Code.

(8) Coordinate enrollment with the individual, the SSA, and ODM's buy-in unit.

(H) Individual responsibilities. An individual:

(1) Who is otherwise eligible for QMB but who is not currently in receipt of part A or part B must apply at the SSA for part A or part B.

(2) Who is otherwise eligible for SLMB but who is not currently in receipt of part A must apply at the SSA for part A.

(3) Must inform the CDJFS of any actions by the SSA on the individual's application for part A or part B, or any changes in the individual's part A or part B coverage.

Replaces: 5160:1-3-02.1

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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Statutory Authority:	5160.02, 5163.02
Rule Amplifies:	5160.02, 5163.02
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5160:1-3-02.1 **Medicare premium assistance programs (MPAP).**

(A) This rule sets forth the eligibility criteria and benefits for the medicare premium assistance programs (MPAP). These programs are: qualified medicare beneficiary (QMB), specified low-income medicare beneficiary (SLMB), qualified individuals (QI-1), and qualified disabled and working individuals (QDWI).

(B) Definitions.

(1) "Enrolled," for the purpose of this rule, means an individual is in receipt of benefits under a medicare health plan.

(2) "Family," for the purposes of MPAP, means the following persons living in the same household as the individual for whom medicare premium assistance is sought or received:

(a) The individual; and

(b) If the individual is a minor, then the biological, adoptive, step parents, legal guardians, or legal custodians of the individual; and

(c) The spouse of the individual and of any persons described in paragraph (B)(2)(b) of this rule; and

(d) The minor dependent children of the individual and of any persons described in paragraphs (B)(2)(b) and (B)(2)(c) of this rule.

(3) "Family of the size involved" means "family" as defined in paragraph (B)(2) of this rule.

(4) "MPAP" means any or all of the medicare premium assistance programs: QMB, SLMB, QI-1, and QDWI.

(5) "MPAP resource limit" means the maximum amount of resources allowed under section 1905(p)(1) of the Social Security Act (as in effect on January 1, 2016), as adjusted annually according to the change in the consumer price index for urban areas (CPI-U).

(6) "Qualified," for the purpose of this rule, means an individual is eligible to receive benefits under a medicare health plan, whether or not the individual has applied for those benefits.

(7) "QDWI" means the qualified disabled and working individuals program established by section 1905(s) of the Social Security Act (as in effect on January 1, 2016). This program is sometimes referred to as the qualified

working disabled individuals (QWDI) program.

(8) "QI-1" means the qualified individual group, described in section 1902(a)(10)(E)(iv) of the Social Security Act (as in effect on January 1, 2016).

(9) "QMB" means the qualified medicare beneficiary group described in section 1905(p)(1) of the Social Security Act (as in effect on January 1, 2016).

(10) "SLMB" means the specified low-income medicare beneficiary group described in section 1902(a)(10)(E)(iii) of the Social Security Act (as in effect on January 1, 2016).

(C) The income standards for the medicare premium assistance programs (MPAP) are as follows:

(1) The QMB income standard is one hundred percent of the federal poverty level for the family of the size involved.

(2) The SLMB income standard is one hundred twenty percent of the federal poverty level for the family of the size involved.

(3) The QI-1 income standard is one hundred thirty-five percent of the federal poverty level for the family of the size involved.

(4) The QDWI income standard is two hundred percent of the federal poverty level for the family of the size involved.

(D) To be eligible for a medicare premium assistance program, an individual must meet all of the following conditions:

(1) Be qualified for coverage under medicare part A (part A).

(a) An individual otherwise qualified for QMB must be enrolled in either medicare part A or medicare part B (part B) for the administrative agency to provide benefits under this rule.

(b) An individual otherwise qualified for SLMB must be enrolled in part A for the administrative agency to provide benefits under this rule.

(c) An individual otherwise qualified for QI-1 must be enrolled in part A for the administrative agency to provide benefits under this rule.

(d) An individual otherwise qualified for QDWI must be enrolled in part A under section 1818A of the Social Security Act (as in effect on February 1, 2016). Coverage can be identified as being provided under section 1818A of the Social Security Act when the individual meets the

following criteria:

(i) Has not reached age sixty-five; and

(ii) Has lost disability benefits under Title II of the Social Security Act (as in effect on February 1, 2016) solely due to earnings in excess of the substantial gainful activity (SGA) level established by the social security administration (SSA); and

(iii) Is paying a premium for part A coverage; and

(iv) Has provided no document or communication from the SSA indicating another basis for part A coverage.

(2) Have resources, as determined under rule 5160:1-3-05 of the Administrative Code, no greater than the MPAP resource limit as defined in paragraph (B)(5) of this rule for the family of the size involved.

(3) Have income, as determined under paragraph (E) of this rule, within the MPAP income standards as set forth in paragraph (C) of this rule.

(4) For QI-1 and QDWI, be otherwise ineligible for medical assistance under Chapters 5160:1-1 to 5160:1-5 of the Administrative Code.

(5) For QDWI, have countable resources, as determined under rule 5160:1-3-05 of the Administrative Code, which do not exceed twice the standard under the supplemental security income (SSI) program.

(6) Meet the application, conditions of eligibility, and verification requirements set forth in Chapter 5160:1-2 of the Administrative Code.

(E) Countable income shall be determined under rule 5160:1-3-05 of the Administrative Code, except the annual cost of living increase (COLA) shall be deducted from the individual's income beginning in January of each year and continuing through the end of the month after the month in which the updated federal poverty guidelines are published in the Federal Register.

(F) Application of income standards.

(1) The MPAP income standards require comparison of the income of the individual combined with the income of the individual's family of the size involved (if any) to the standards set forth in paragraph (C) above.

(2) The income of both the individual and the individual's family of the size involved (if any) must be determined by considering all income as defined in rule 5160:1-3-03.1 of the Administrative Code and applying all exclusions listed in rule 5160:1-3-03.11 of the Administrative Code, except that the

twenty-dollar general and sixty-five-dollar earned income exclusion shall be applied only once to a married couple in the MPAP eligibility determination.

(3) The deeming provisions set forth in rule 5160:1-3-03.9 of the Administrative Code do not apply to MPAP eligibility determinations.

(G) Coordination of enrollment. If an individual is eligible for benefits under this rule, the county department of job and family services (CDJFS) shall coordinate the individual's receipt of benefits.

(1) If the individual:

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

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

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

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

(iii) 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

(iv) Approve MPAP 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.

(2) After three weeks, if the electronic submission was not successful, the CDJFS shall submit a completed ODM 07102 "Changes in Medicaid Health Care Coverage Date and Medicare Buy-In Eligibility" (rev. 07/2014) to the ODM buy-in unit.

(H) Coverage periods.

(1) The effective date of QMB coverage is the first day of the month after the month in which the administrative agency approves QMB benefits. No retroactive coverage is available for QMB.

(2) Eligibility for SLMB benefits begins no earlier than the third month prior to the month of application, provided the individual met all eligibility criteria including enrollment in part A during the three-month period.

(3) Eligibility for QI-1 benefits begins no earlier than the third month prior to the month of application, provided the individual met all eligibility criteria including enrollment in part A during any part of the three-month period.

(4) Eligibility for QDWI benefits begins no earlier than the third month prior to the month of application, provided the individual met all eligibility criteria including enrollment in part A during the three-month period.

(5) Eligibility for payment of medicare premiums under this rule ends on the earliest of the following dates:

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

(b) The last day of the last 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 MPAP, if notice was provided to the centers for medicare and medicaid (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 MPAP, if notice was not provided within the time limit in paragraph (E)(2)(c) of this rule.

(I) Benefits.

(1) If an individual is eligible for QMB, the administrative agency shall pay the individual's:

(a) Premiums for part B and, if a premium is charged, part A; and

(b) Medicare deductibles; and

(c) Medicare co-pays; and

(d) Medicare coinsurance costs.

(2) If an individual is eligible for SLMB, QI-1, or QDWI the administrative agency shall pay the individual's part B premiums.

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

(1) Explore eligibility for medicaid and for all MPAP categories if a medicaid applicant is qualified for part A. The agency shall advise the individual:

(a) Of the categories of medicaid or MPAP for which the individual is eligible, the individual's right to decline payment of premiums, co-pays, or coinsurance costs, and the effect of declining MPAP payments; and

(b) That if an individual is qualified for benefits under part A or part B, the Ohio department of medicaid (ODM) is prohibited from paying for prescriptions on behalf of that individual, whether or not a premium would be charged for those benefits.

(2) If an individual is eligible for QMB:

(a) Approve benefits under QMB and pay the part A, if applicable, and part B premiums on behalf of a QMB-eligible individual effective the month after the administrative agency approves QMB coverage; and

(b) For individuals who are not receiving free part A, but who could receive part A benefits by paying a premium, coordinate enrollment in parts A and B with ODM and the social security administration (SSA).

(3) If the individual is eligible for SLMB, approve benefits under SLMB and pay the individual's part B premium effective the month SLMB coverage begins.

(4) If an individual is eligible for QI-1, approve benefits under QI-1 and pay the individual's part B premium effective the month QI-1 coverage begins.

(5) If an individual is eligible for QDWI, approve benefits under QDWI and pay the individual's monthly part A premium effective the month that QDWI coverage begins.

(6) Determine whether coverage for any category of benefits under this rule should have been effective prior to the effective date in the electronic medicare buy-in system. If coverage should have begun earlier, the CDJFS shall request that ODM manually buy-in the individual with the correct coverage effective date.

(7) Deny benefits under this rule if:

(a) Any of the criteria under this rule is not met; or

(b) Any of the conditions for denial set forth in rules 5160:1-2-08 and 5160:1-2-10 of the Administrative Code are met; or

(c) The individual is eligible only for benefits under QI-1 and there is insufficient funding for the QI-1 program.

(8) Terminate benefits under this rule if:

(a) An individual no longer meets the eligibility criteria for any covered group under this rule; or

(b) Any of the conditions for termination set forth in rules 5160:1-2-08 and 5160:1-2-10 of the Administrative Code are met; or

(c) The individual was eligible for benefits under QI-1 but becomes eligible for another category of medicaid.

(9) Coordinate enrollment with the individual, the SSA, and ODM's buy-in unit.

(K) Individual responsibilities. An individual:

(1) Who is otherwise eligible for QMB but who is not currently in receipt of part A or part B must apply at the SSA for part A or part B.

(2) Who is otherwise eligible for SLMB, QI-1, or QDWI but who is not currently in receipt of part A must apply at the SSA for part A.

(3) Must inform the CDJFS of any actions by the SSA on the individual's application for part A or part B, or any changes in the individual's part A or part B coverage.

Replaces: 5160:1-3-02.1, 5160:1-3-02.2

Effective:

Five Year Review (FYR) Dates:

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TO BE RESCINDED

5160:1-3-02.2 Medicare: qualified disabled and working individuals (QDWI).

(A) This rule sets forth the eligibility requirements, coverage period, and benefits of the qualified disabled and working individuals (QDWI) program.

(B) Definitions.

(1) "Enrolled," for the purposes of this rule, means that an individual is in receipt of benefits under a medicare health plan.

(2) "QDWI" means the qualified disabled and working individuals program established by section 1905(s) of the Social Security Act (as in effect on December 1, 2013). This program is sometimes referred to as the qualified working disabled individuals (QWDI) program.

(C) Eligibility. To receive QDWI benefits, an individual must:

(1) Be enrolled in medicare part A (part A) under section 1818A of the Social Security Act (as in effect on December 1, 2013). Coverage can be identified as being provided under section 1818A of the Social Security Act when the individual:

(a) Has not reached age sixty-five; and

(b) Has lost disability benefits under Title II of the Social Security Act (as in effect on December 1, 2013) solely due to earnings in excess of the substantial gainful activity (SGA) level established by the social security administration (SSA); and

(c) Is paying a premium for part A coverage; and

(d) Has provided no document or communication from the SSA indicating another basis for part A coverage.

(2) Have countable income, as determined under Chapter 5160:1-3 of the Administrative Code, which does not exceed two hundred per cent of the federal poverty level for the individual's family size.

(3) Have countable resources, as determined under Chapter 5160:1-3 of the Administrative Code, which do not exceed twice the standard under the supplemental security income (SSI) program.

(4) Not be otherwise eligible for medicaid.

(5) Meet the application, conditions of eligibility, and verification requirements set forth in Chapter 5160:1-2 of the Administrative Code.

(D) Coverage period.

(1) Eligibility for QDWI benefits begins no earlier than the third month prior to the month of application, provided the individual met all eligibility criteria including enrollment in part A during the three-month period.

(2) The date and effect of termination of QDWI benefits is set forth in rule 5160:1-3-02.6 of the Administrative Code.

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

(1) Deny benefits under this rule if any of the conditions for denial set forth in rules 5160:1-2-01 and 5160:1-2-10 of the Administrative Code are met; or

(2) Terminate benefits under this rule if any of the conditions for termination set forth in rules 5160:1-2-01 and 5160:1-2-10 of the Administrative Code are met; or

(3) Approve benefits if an individual is eligible for QDWI benefits, and pay the individual's monthly part A premium as set forth in rule 5160:1-3-02.6 of the Administrative Code, effective the month that QDWI coverage begins.

(F) Individual responsibilities. The individual must inform the county department of job and family services (CDJFS) of any changes in the individual's part A or part B coverage.

Replaces: 5160:1-3-02.1

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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TO BE RESCINDED

5160:1-3-02.6 **Medicare buy-in.**

(A) This rule sets forth:

(1) The eligibility criteria for benefits under the medicare 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 those individuals are not eligible for a medicare premium assistance program (MPAP) set out in rule 5160:1-3-02.1 of the Administrative Code; and

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

(3) The date and effect of termination of benefits under the medicare buy-in or an MPAP; and

(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 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 individuals even if those individuals are not eligible for benefits under rule 5160:1-3-02.1 or 5160:1-3-02.2 of the Administrative Code.

(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 other than:

(a) Medicaid with a spenddown calculated under rule 5160:1-3-04.1 of the Administrative Code; or

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

(c) Presumptive medicaid as set forth in rule 5160:1-1-62 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 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 5160:1-1-65 of the Administrative Code.

(d) Grandfathered medicaid as set forth in rule 5160:1-3-02.3 of the Administrative Code.

(e) Foster care maintenance payments or adoption assistance payments as set forth in rule 5160:1-1-63 of the Administrative Code.

(f) Medicaid as a result of section 1619(b) of the Social Security Act (as in effect October 1, 2014) as set forth in rule 5160:1-3-02.4 of the Administrative Code.

(g) Deemed OWF as described in 42 C.F.R 435.115 (as in effect October 1, 2014).

(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, including the program of all inclusive care for the elderly (PACE), under a waiver described in agency 5160 of the Administrative Code.

(D) Coordination of enrollment. If an individual is eligible for benefits under this rule or rule 5160:1-3-02.1 or 5160:1-3-02.2 of the Administrative Code, or would be eligible if the individual were enrolled in part A or part B, the county department of job and family services (CDJFS) shall coordinate the individual's receipt of benefits.

(1) If the individual:

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

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

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

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

(iii) 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

(iv) Approve MPAP or 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.

(2) After three weeks, if the electronic submission was not successful, the CDJFS shall submit a completed ODM 07102 "Changes in Medicaid Health Care Coverage Date and Medicare Buy-In Eligibility" (rev. 07/2014) to the ODM buy-in unit.

(E) Coverage period.

(1) Start date.

(a) For MPAP benefits under rule 5160:1-3-02.1 of the Administrative Code or for QDWI under rule 5160:1-3-02.2 of the Administrative Code, the beginning date for payment of premiums is addressed in those rules. If 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, if 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, rule 5160:1-3-02.1 of the Administrative Code, or rule 5160:1-3-02.2 of the Administrative Code ends on the earliest of the following dates:

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

(b) The last day of the last 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 MPAP, QDWI, or medicare part B buy-in benefits, if notice was provided to the centers for medicare and medicaid (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 MPAP, QDWI, or medicare part B buy-in benefits, if notice was not provided within the time limit 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.

Replaces: 5160:1-2-02.2

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	111.15
Statutory Authority:	5160.02, 5163.02
Rule Amplifies:	5160.02, 5163.02
Prior Effective Dates:	8/15/82, 10/1/02, 1/1/10, 1/22/2015

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

(A) This rule sets forth:

(1) The eligibility criteria for benefits under the medicare 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 those individuals are not eligible for a medicare premium assistance program (MPAP) set out 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 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 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 Code; or

(b) Presumptive medicaid 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 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 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 as a result of section 1619(b) of the Social Security Act (as in effect February 1, 2016) as set forth in rule 5160:1-3-02.8 of the Administrative Code.

(g) Deemed OWF as described in 42 C.F.R 435.115 (as in effect February 1, 2016).

(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, including the program of all inclusive care for the elderly (PACE), under a waiver described in agency 5160 of the Administrative Code.

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

(1) If the individual:

(a) 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.

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

(i) Inform the individual that the Ohio department of medicaid (ODM)

cannot pay medicare premiums until the individual has enrolled in part A or part B through the SSA; and

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

(iii) 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

(iv) 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.

(2) After three weeks, if the electronic submission was not successful, the CDJFS shall submit a completed ODM 07102 "Changes in Medicaid Health Care Coverage Date and Medicare Buy-In Eligibility" (rev. 07/2014) to the ODM buy-in unit.

(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 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, if 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 earliest of the following dates:

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

(b) The last day of the last 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 medicare part B buy-in benefits, if notice was provided to the centers for medicare and medicaid (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 medicare part B buy-in benefits, if notice was not provided within the time limit 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.

Replaces: 5160:1-3-02.6

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	111.15
Statutory Authority:	5160.02, 5163.02
Rule Amplifies:	5160.02, 5163.02
Prior Effective Dates:	8/15/82, 10/1/02, 1/1/10

TO BE RESCINDED

5160:1-3-03.5 **Medicaid: need standards.**

(A) The purpose of this rule is to set forth the need standards used in medicaid eligibility determinations for aged, blind, or disabled individuals.

(B) Definitions.

(1) "Need standard" means the income limit above which an individual is either ineligible for a given category of medicaid for the aged, blind or disabled, or is subject to a spenddown in accordance with rules 5160:1-3-03.4 and 5160:1-3-03.9 of the Administrative Code.

(2) "Couple need standard" is equal to the current supplemental security income (SSI) benefit rate for a couple. The updated figure is published annually by the social security administration.

(3) "Individual need standard" is a dollar amount, adjusted annually by the same percentage as the social security cost of living allowance (COLA). The updated figure is published annually in the medicaid eligibility manual via a medicaid eligibility procedure letter (MEPL).

(4) The "special income level" for institutionalized individuals is equal to three hundred per cent of the current supplemental security income (SSI) benefit payment rate for an individual.

(5) The need standards for the medicare premium assistance programs (MPAP) are as follows:

(a) The QMB need standard is one hundred per cent of the federal poverty level.

(b) The SLMB need standard is one hundred twenty per cent of the federal poverty level.

(c) The QI need standard is one hundred thirty-five per cent of the federal poverty level.

(d) The QDWI need standard is two hundred per cent of the federal poverty

level.

(C) Application of need standards.

(1) For an individual, countable income is compared to the appropriate individual need standard. An institutionalized individual, even if married, is treated as an individual.

(2) For a married couple:

(a) If both members of the married couple are categorically eligible, countable income is compared to the appropriate couple need standard.

(b) If only one member of the married couple is categorically eligible, countable income may be compared to either the individual need standard or the couple need standard, in accordance with the deeming provisions set forth in rule 5160:1-3-03.9 of the Administrative Code.

Replaces: 5160:1-3-03.5

Effective:

Five Year Review (FYR) Dates:

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Date

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5160:1-3-03.5 Medicaid: application of income standards.

(A) The purpose of this rule is to set forth the application of income standards used in medicaid eligibility determinations for aged, blind, or disabled individuals.

(B) Definitions.

(1) "Income standard" means the income limit above which an individual is ineligible for a given category of medicaid for the aged, blind or disabled.

(2) "Couple income standard" is equal to the current supplemental security income (SSI) benefit rate for a couple. The updated figure is published annually by the social security administration.

(3) "Individual income standard" is equal to the current supplemental security income (SSI) benefit rate for an individual. The updated figure is published annually by the social security administration.

(4) The "special income level" for institutionalized individuals is equal to three hundred percent of the current supplemental security income (SSI) benefit payment rate for an individual.

(C) Application of income standards.

(1) For an individual, countable income is compared to the appropriate individual income standard. An institutionalized individual, even if married, is treated as an individual.

(2) For a married couple:

(a) If both members of the married couple are categorically eligible, countable income is compared to the appropriate couple income standard.

(b) If only one member of the married couple is categorically eligible, countable income may be compared to either the individual income standard or the couple income standard, in accordance with the deeming provisions set forth in rule 5160:1-3-03.9 of the Administrative Code.

Replaces: 5160:1-3-03.5

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Explanation of
Qualified Medicare Beneficary
(QMB)

Medicaid Coverage

You have been found eligible for QMB Medicaid.

Under the provisions of the Medicare Catastrophic Coverage Act of 1988, the Ohio Medicaid program will pay the Medicare premiums, deductibles, and coinsurance for Qualified Medicare Beneficiaries (QMBs).

The QMB Medicaid card is limited to the cost sharing expenses of Medicare. The card will pay for Medicare (Part A and Part B) premiums, deductibles and coinsurance. The QMB Medicaid card will not cover the following services:

- Routine checkups
- Outpatient prescription drugs
- Glasses, or examination for glasses
- Hearing aids, or examinations for hearing aids
- Routine foot care (treatment of warts is covered however)
- Orthopedic shoes
- Most dental work
- Most immunizations (pneumococcal and hepatitis B vaccinations are covered, however)
- Private duty nurses
- "Custodial care," unless part of hospice care.
- First three pints of blood or packed red blood cells, applied separately under both Part A and Part B
- Homemaker services (except as part of hospice care) and meals delivered to the home

In some instances an individual may be eligible for QMB Medicaid and for delayed spend-down Medicaid. Individuals who are eligible for both programs, will receive a QMB Medicaid card the first of the month and a spend-down Medicaid card whenever the spend-down is verified. It is to the individual's advantage to meet the spend-down as early as possible in the month since the QMB Medicaid card will not cover many of the medical services they may need. The individual must meet the spend down by incurring medical expenses that are not covered under the QMB Medicaid card, such as prescriptions and vision examinations. Once an individual receives the spend-down Medicaid card, it should be used for all medical services.

If you have questions about QMB Medicaid or delayed spend-down Medicaid, call your caseworker at the County Department of Job and Family Services.

For QMB recipients Medicare determines what it will pay the doctor. The amount he receives from Medicare plus the amount of the coinsurance or deductible he receives from QMB Medicaid is considered payment in full. The doctor can not send you a bill for an additional amount.

If a provider is not required to, and does not accept Medicare assignment under Part B, he can not bill an individual who is a QMB only recipient for the difference between his charge for the service and Medicare's rate for the service.

If you are eligible for QMB and regular or ongoing spend-down Medicaid and the provider accepts you as a Medicaid patient, then any Medicaid payment for the Medicare covered service is considered payment in full and the provider can not try to collect any difference between his charge and Medicare's rate for the service.

If your doctor or other provider does not have a Medicaid contract with the state of Ohio then QMB cannot pay the deductible or coinsurance. You will be responsible for the bill. You will need to ask your medical provider if he or she has a Medicaid contract with Ohio.