OHIO DEPT. OF JOB AND FAMILY SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43218-2825

Ohio Department of Job and Family Services
Bureau of State Hearings

State Hearing Decision

Appeal	Program	Disposition	Compliance
3801304	MED-E	OVR	Not Required
3801305	MED-E	OVR	Not Required
3809935	MED-E	SUS	Required

Request Date: 10/06/2023
Hearing Date: 11/13/2023 Hearing Officer: Marty Habas
Mail Date: 11/20/2023

English

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Issue

Appeal Number: 3801304, Medicaid Eligibility Issues, Denial - MEDICARE

Was the County Department of Job and Family Services (CDJFS) correct to deny the Appellant's application for the Medicare Premium Assistance Program for Qualified Individuals (QI-1), due to countable income greater than 135% of the federal poverty level? After careful consideration of the information presented during this state hearing, I found the denial was supported.

Appeal Number: 3801305, Medicaid Eligibility Issues, Discontinuance - MAGI

Was the County Department of Job and Family Services (CDJFS) correct to discontinue the Appellant's Adult MAGI Medicaid due to the Appellant being in receipt of Medicare? After careful consideration of the information presented during this state hearing, I found the program that was discontinued was the ABD Medicaid and the MAGI Medicaid was wrongly listed. It could not be changed as the Fair Hearing Benefits were attached to it. The appeal will be overruled.

Appeal Number: 3809935, Medicaid Eligibility Issues, Discountenance - ABD

Was the County Department of Job and Family Services (CDJFS) correct to propose to terminate the Appellant's Medicaid, because the individual's countable income is greater than the applicable income standard, supported by the County Department of Job and Family Services(CDJFS)? After careful consideration of the information presented during this state hearing, I found the denial of Medicaid was not supported.

Procedural Matters

The Appellant's mother (Authorized Representative/AR) was present at the hearing. The Appellant's Attorney was also present. The CDJFS was represented by Venee Burton, Eligibility Specialist. The Authorized Representative and CDJFS Representative were sworn in. The Attorney was there to explain arguments and not to testify.

Findings of Fact

1. The assistance group (AG) consists of the Appellant, age 44 who has been disabled since childhood.
2. On August 2, 2023, the CDJFS mailed the Appellant a renewal packet.
3. On August 11, 2023, the Appellant returned the renewal packet.

4. The Appellant receives $1,690 per month as a disabled child on his parent's social security. He was determined eligible for Supplemental Security Income (SSI) on February 28, 1997, at age 17 (Appellant's Exhibit 2) and maintained SSI eligibility until his parents retired.
5. On September 14, 2023, the CDJFS completed the renewal.
6. The CDJFS stated they completed a Pre-termination Review and could not find the Appellant eligible for any other Medicaid programs.
7. On September 27, 2023, the CDJFS mailed notice of action proposing termination of the Appellant's Medicaid for the Disabled, due to exceeding the SSI standard of $914 for categorically needy Medicaid effective October 31, 2023.
8. The CDJFS also mailed notice of action denying the Appellant's Medicare Premium Assistance Program Medicaid.

Conclusion of Policy

Policy

(A) Various grandfathering provisions and deemed eligibility requirements were enacted to assure that aged, blind, or disabled individuals previously eligible for cash assistance and medicaid under former programs of aid would not be disadvantaged by eligibility conditions when the supplemental security income (SSI) program was implemented.

(B) Definitions.

(1) "Cash assistance," for the purpose of this rule, means the receipt of at least one of the following: Ohio works first (OWF), SSI or residential state supplement (RSS), or the former programs of aid known as aid for dependent children (ADC), aid for the aged (AFA), aid for the blind (AFB), and aid for the disabled (AFD).

(2) "Essential spouse" for the purpose of this rule means one who is living with the individual whose needs were included in determining the amount of cash assistance and who is determined essential to the individual's well-being.

(C) Under the grandfathering provisions, certain individuals who were eligible for medicaid in December 1973 are entitled to continued medicaid eligibility coverage even though they may not meet the medicaid eligibility requirements imposed beginning in January 1974 for the coverage of the aged, blind, and disabled.

(1) The grandfathered groups are the following:

(a) Individuals receiving mandatory state supplements as described in 42 C.F.R. 435.130 (as in effect October 1, 2019): an individual who is the recipient of

mandatory state supplement payments (SSP) administered by the social security administration is automatically eligible for medicaid.

(b) Individuals who are essential spouses as described in 42 C.F.R. 435.131 as in effect October 1, 2019): any individual who was eligible in December 1973 as an essential spouse remains eligible under the following criteria:

(i) The aged, blind or disabled spouse continues to meet the December 1973 eligibility requirements of the applicable cash assistance programs; and

(ii) The essential spouse continues to be the spouse of and lives with the spouse described in paragraph (C)(1)(b)(i) of this rule; and

(iii) The essential spouse continues to meet the conditions that were in effect in December 1973 under the applicable cash assistance program for having his or her needs included in computing the payment to the individual described in paragraph (C)(1)(b)(i) of this rule.

(c) Blind or disabled individuals eligible in 1973 as described in 42 C.F.R. 435.133 (as in effect October 1, 2019): an individual who was eligible for medicaid in December 1973 because the individual met the definition of blindness or disability in effect under the former programs of AFB or AFD and meets the following criteria:

(i) The individual meets all current requirements for medicaid eligibility except for blindness or disability; and

(ii) The individual was eligible for medicaid in December 1973 as blind or disabled, whether or not the individual received cash assistance in December 1973; and

(iii) For each consecutive month after December 1973, the individual has continued to meet the December 1973 criteria for blindness or disability; and

(iv) For each consecutive month after December 1973, the individual has continued to meet all other eligibility requirements which were in effect December 1973.

(d) Individuals who lost eligibility for SSI due to an increase in retirement, survivors and disability insurance (RSDI) as described in 42 C.F.R. 435.134 (as in effect October 1, 2019): individuals eligible despite the October 1972 twenty per cent general increase:

(i) An individual who would currently be eligible for SSI or cash assistance

except for the amount of increased income resulting from the October 1972 twenty per cent general increase in RSDI is eligible for medicaid if, for the month of August 1972, the individual met the following criteria:

(a) The individual was eligible for and receiving cash assistance under the ADC, AFA, AFB, or AFD programs, and

(b) The individual received and was entitled to monthly RSDI benefits.

(ii) Only the October 1972 RSDI increase is disregarded. Any subsequent increases in RSDI are not disregarded.

(iii) Although the amount of the October 1972 RSDI increase is disregarded in determining financial eligibility, the individual must meet all of the current eligibility requirements for medicaid.

(e) Institutionalized individuals continuously eligible since 1973 as described in 42 C.F.R. 435.132 (as in effect October 1, 2019): an individual who was eligible for medicaid in December 1973 as an inpatient or resident of a Title XIX institution and for each consecutive month after December 1973 meets the following criteria:

(i) Continues to meet the requirements for medicaid eligibility that were in effect in December 1973 for institutionalized individuals; and

(ii) Remains institutionalized; and

(iii) Is determined to continue to need institutional care.

(f) Individuals who would be eligible for SSI but not for RSDI COLA increases since April 1977 (Pickle Amendment Group) as described in 42 C.F.R. 435.135 (as in effect October 1, 2019): an individual receiving RSDI and meets the following criteria:

(i) Became ineligible for SSI after April 1977; and

(ii) Would continue to be eligible for SSI if all of the RSDI cost-of-living increases received by the individual, the individual's spouse or other family member after April 1977 were deducted from current RSDI benefits.

(g) Ineligible for SSI due to requirements prohibited by Medicaid as described in 42 C.F.R. 435.122 (as in effect October 1, 2019): individuals who would be eligible for SSI or residential state supplements except for an eligibility requirement used in those programs that is specifically prohibited under medicaid.

(2) Failure to meet any one of the conditions listed in paragraph (C)(1) of this rule renders the individual ineligible for grandfathered status under the blind or disabled grandfathering provisions.

(3) An individual described in paragraph (C)(1)(c) of this rule permanently loses grandfathered status when the individual fails to meet any December 1973 eligibility requirement for any one month.

(4) Any change in circumstances requires a redetermination of eligibility based upon all the conditions set forth in paragraph (C)(1) of this rule.

(5) Eligibility under a grandfathered group does not apply to individuals in a long-term care facility or enrolled in a home and community-based services waiver.

(D) Under deemed eligibility, certain individuals who were ineligible for SSI, due to receipt of social security benefits, are entitled to continued Medicaid coverage for the aged, blind and disabled if certain criteria are met.

(1) The deemed eligibility groups are the following:

(a) Disabled widows(ers) ineligible for SSI or RSS due to increase in RSDI as described in 42 C.F.R. 435.137 (as in effect October 1, 2019): disabled widows(ers) who became ineligible for SSI or RSS benefits as a result of the elimination of the additional reduction factor for disabled widows(ers) under age sixty and meet all of the following criteria:

(i) Entitled to a monthly RSDI benefit for December 1983, and

(ii) Entitled to and received a social security widow(er)'s disability benefit in January 1984, and

(iii) Became ineligible for SSI benefits in the first month in which the increase in social security disabled widows(ers) benefits, as a result of the elimination of the additional reduction factor, was received, and

(iv) Continuously entitled to widow(er)'s disability benefits from the first month that the increase was received, and

(v) Would be eligible for SSI or RSS if the increase in RSDI benefits due to the elimination of the reduction factor and subsequent cost-of-living adjustments in RSDI benefits were excluded, and

(vi) Filed a medicaid application or renewal on or before June 30, 1988 for

deemed eligibility.

(b) *Disabled adult children as described in section 1634 of the Social Security Act (as in effect October 1, 2019): disabled individuals who have attained the age of eighteen and received SSI benefits on the basis of blindness or disability which began before he or she attained the age of twenty-two and meet all of the following criteria:*

(i) Entitled to social security child's insurance benefits on the basis of disability or an increase in the amount of the child's insurance benefits which are payable, and

(ii) Became ineligible for SSI benefits solely because of their receipt of social security child's insurance benefits or increase in social security child's insurance benefits, and

(iii) Would be eligible for SSI if the social security child's insurance benefits were excluded.

(c) Disabled widows(ers) ineligible for SSI due to early receipt of social security as described in 42 C.F.R. 435.138 (as in effect October 1, 2019): disabled widows(ers) at least age sixty who became ineligible for SSI as a result of the receipt of widows(ers) social security disability benefits and meet all of the following criteria:

(i) Receives widows(ers) social security disability benefits, and

(ii) Became ineligible for SSI benefits solely because of the receipt of widows(ers) social security disability benefits, and

(iii) Received a SSI benefit in the month before the month of receipt of widows(ers) social security disability benefits, and

(iv) Not entitled to medicare part A.

(v) Although the amount of the widows(ers) social security disability benefits is excluded in determining financial eligibility, the individual must meet all of the current eligibility requirements for medical assistance.

(2) Any changes in circumstances requires a redetermination of eligibility based upon all conditions set forth in paragraph (D)(1) of this rule.

(3) Eligibility under a deemed group does not apply to individuals in a long-term care facility or enrolled in a home and community-based services waiver. Ohio Admin. Code

5160:1-3-02.6

Gross Income calculation for Medicaid

(B) Gross monthly income shall be calculated as follows:

(1) The amount of gross monthly non-excluded income shall first be established. Disregards and deductions, as defined in rule 5160:1-1-01 of the Administrative Code, shall then be subtracted when applicable.

(2) In calculating gross income, both earned and unearned, the monthly amounts shall be rounded down to the nearest whole dollar by dropping the cents.

(3) To correctly calculate gross income that is not received on a monthly basis, use the following conversion factors. All cents in gross weekly, bi-weekly, or semi-monthly income shall be dropped before and after multiplying.

(a) Income received weekly shall be multiplied by 4.3.

(b) Income received bi-weekly (every two weeks) shall be multiplied by 2.15.

(c) Income received semi-monthly (twice per month) shall be multiplied by 2.0.

(d) Gross annual income received shall be divided by 12.0.

(e) For contract employees, divide the gross payment amount by the number of calendar months the contract covers. This also applies when a one-time payment is made for work that is done over a period.

(4) Hourly rates that contain cents are not rounded when determining a weekly, bi-weekly, or semi-monthly amount. Ohio Administrative Code 5160:1-2-02.

Medicaid for Categorically Needy Standard

Individuals residing in the community whose Medicaid eligibility is dependent upon meeting the requirements for aged, blind or disabled individuals may not have countable income in excess of the current SSI benefit rate for either a couple or an individual, whichever applies. The current SSI benefit rate for an individual is $914. Ohio Administrative Code 5160:1-3-03.5.

Medicaid limiting Physical Factor

The Medicaid program provides coverage for individuals who meet the criteria for the limiting physical factors of age, blindness, or disability. In order to meet this requirement by

age, the individual must be 65 or older, and age is determined by county departments of job and family services. Blindness and disability are determined by either the Social Security Administration (SSA) or the Ohio Department of Medicaid. As well, the limiting physical factor is met when an individual has been determined to need a skilled or intermediate level of care. Ohio Administrative Code 5160:1-3-02.

Medicare Premium Assistance Program

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 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 October 1, 2019). 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 sixty-five years of age; and

(ii) Has lost disability benefits under Title II of the Social Security Act (as in effect October 1, 2019) solely due to earnings in excess of the substantial gainful activity (SGA) level established by the 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) For QMB, SLMB, and QI-1, have countable resources that do not exceed the MPAP resource limit as defined in paragraph (B)(7) of this rule, for an individual or the MPAP resource limit for a couple (the individual and the individual's spouse). Countable resources shall be determined in accordance with Chapter 5160:1-3 of the Administrative Code.

(3) For QDWI, have countable resources that do not exceed twice the maximum amount of

resources that an individual or couple (the individual and the individual's spouse) may have under the supplemental security income (SSI) program. Countable resources shall be determined in accordance with Chapter 5160:1-3 of the Administrative Code.

(4) Have countable income, as determined in accordance with paragraph (E) of this rule, within the MPAP income standards as set forth in paragraph (C) of this rule.

(5) For QI-1 and QDWI, be otherwise ineligible for medical assistance in accordance with Chapters 5160:1-3, 5160:1-4, 5160:1-5, and 5160:1-6 of the Administrative Code.

(6) Meet the application, conditions of eligibility, and verification requirements set forth in Chapter 5160:1-2 of the Administrative Code. Ohio Admin. Code §5160:1-3-02.1(D).

The 135% federal poverty level standard for an Assistance Group of one for the highest financial eligibility for the Medicare Premium Assistance Program (MPAP) for QI 1 is $1,641. Medicaid Eligibility Procedure Letter (MEPL) 173.

Pre-termination Review

"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. Ohio Administrative Code 5160:1-1-01 (B)(68)

Medicaid Unwinding

Per CMS guidance, the first renewal month that could result in discontinuance of Medicaid coverage is April 2023. At the option of the state, Ohio has elected to begin renewals in the month before the continuous coverage condition ends (i.e., February 2023). The state

must initiate renewals for all individuals who are enrolled as of the last day of the continuous coverage condition within 12 months (i.e., by January 31, 2024) and must complete renewals for all individuals enrolled as of the last day of the continuous coverage condition within 14 months (i.e., by March 31, 2024).

For the month of April 2023, renewals will be initiated in February 2023 and an individual who is determined by the administrative agency to no longer meet all eligibility requirements, or who does not timely return information needed by the administrative agency to complete the renewal, will have coverage discontinued effective May 1, 2023 (with the individual's last date of coverage being April 30, 2023). Renewals for individuals initiated prior to February 2023 that did not result in a determination of eligibility must be initiated again during the state's 12-month unwinding period. Medicaid Eligibility Procedure Letter (MEPL) 172

Analysis

Appeal Number: 3801304, Medicaid Eligibility Issues, Denial - MEDICARE

The Appellant has income of $1,690 per month. The QI-1 MPAP has the highest income standard for MPAP programs at $1,641. The Appellant is over income for the Medicare Premium Assistance Program. However, the Appellant's Medicare Premium was being paid while he was in receipt of Medicaid. It is a practice of the Ohio Department of Medicaid, to make payment of the Medicare premium for those individuals who are in receipt of Medicaid. I find that the denial is supported based on income. However, if the Appellant's Medicaid eligibility is approved, the Agency should review the payment of the Appellant's Medicare premium through other means.

Appeal Number: 3801305, Medicaid Eligibility Issues, Discontinuance - MAGI

I found the program that was discontinued was the ABD Medicaid and the MAGI Medicaid was wrongly listed. It could not be changed as the Fair Hearing Benefits were attached to it. The appeal will be overruled.

Appeal Number: 3809935, Medicaid Eligibility Issues, Denial - ABD

On August 11, 2023, the Appellant returned the September Medicaid renewal packet. The Appellant receives $1,690 per month as a disabled child on his parent's social security claim. He was determined eligible for Supplemental Security Income (SSI) on February 28, 1997, at age 17 (Appellant's Exhibit 2) and maintained SSI eligibility until his parents retired. On September 14, 2023, the CDJFS completed the renewal. On September 27, 2023, the CDJFS mailed notice of action proposing termination of the Appellant's Medicaid

for the Disabled, due to exceeding the SSI standard of $914 for categorically needy Medicaid effective October 31, 2023.

Upon review of the case, I find that the Appellant meets the standards of a 1634 Social Security determination. Per the Ohio Administrative Code, Medicaid coverage is maintained for "Disabled adult children as described in section 1634 of the Social Security Act (as in effect October 1, 2019): disabled individuals who have attained the age of eighteen and received SSI benefits on the basis of blindness or disability which began before he or she attained the age of twenty-two and meet all of the following criteria:

> (i) Entitled to social security child's insurance benefits on the basis of disability or an increase in the amount of the child's insurance benefits which are payable, and
>
> (ii) Became ineligible for SSI benefits solely because of their receipt of social security child's insurance benefits or increase in social security child's insurance benefits, and
>
> (iii) Would be eligible for SSI if the social security child's insurance benefits were excluded."

The Appellant was in receipt of SSI until his parent's retired when he could claim Social Security as a disabled child on their benefits. He was determined eligible for SSI prior to his 22nd birthday. The CDJFS argues that the Appellant is a 1616 case which deals with optional state cash assistance. However, the Appellant can maintain both 1616 and 1634 status, and the Appellant per the Ohio Administrative Code meets the 1634 criteria. Therefore, the appeal is sustained with compliance.

Hearing Officer's Recommendation

Appeal Number: 3801304

Based on the record and policy before me, I recommend that appeal 3801304 be Overruled.

Appeal Number: 3801305

Based on the record and policy before me, I recommend that appeal 3801305 be Overruled.

Appeal Number: 3809935

Based on the record and policy before me, I recommend that appeal 3809935 be Sustained

with Compliance for CDJFS.

To comply, the CDJFS shall:

1. Rescind the September 27, 2023, proposed termination of the Appellant's Medicaid for the Disabled, categorically needy Medicaid.
2. Reopen the Medicaid for the Disabled, categorically needy Medicaid, sending notice of the Approval to the Appellant, allowing for all appeal rights.

Final Administrative Decision and Order

Regarding appeal number 3801304, I find the Hearing Officer's decision to be supported by the evidence and regulations. The recommendations above are adopted, and the appeal is overruled.

Regarding appeal number 3801305, I find the Hearing Officer's decision to be supported by the evidence and regulations. The recommendations above are adopted, and the appeal is Overruled.

Regarding appeal number 3809935, I find the Hearing Officer's decision to be supported by the evidence and regulations. The recommendations above are adopted, and the appeal is Sustained with Compliance.Compliance is required within fifteen days, but in no event later than ninety calendar days from the date of the hearing request. Compliance must be promptly reported to the Bureau of State Hearings via the "State Hearing Compliance," JFS 04068. Documentation of the compliance action must be attached to the form. Ohio Admin. Code § 5101:6-7-03 (B).

Daniel George

11/20/2023

Notice to Appellant

This is the official decision of your state hearing. It informs you of the decision and order in your case. Papers and materials introduced at the hearing, known as "exhibits," make up the hearing record. The hearing record is maintained by the Ohio Department of Job and Family Services. If you would like a copy of the official record, please call the ODJFS hotline at 1-866-635-3748.

Important Notice: If you disagree with this decision, you, or your authorized representative, may request an administrative appeal about this notice. Contact us using one of the following methods:

Email - bsh@jfs.ohio.gov. In the subject, put "Administrative Appeal Request".
Fax - (614) 728-9574
Mail - ODJFS Bureau of State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825.

Your administrative appeal request should include a copy of this notice and the reason you think it is wrong. Your written request must be received by the Bureau of State Hearings within 15 calendar days from the mailing date of this notice. (If the 15th day falls on a weekend or holiday, this deadline is extended to the next work day.)

Unless you request an administrative appeal, this notice is a final and binding decision about your state hearing request. Any fair hearing benefits you receive will end. This may also mean the local agency can go ahead with the action it was planning to take. Additionally, you may have to pay back the continuing benefits you received as part of the state hearing process.

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Appendix

Appellant Exhibits

1. Request-SH (24 pages)
2. Exhibit - Appellant (4 pages)

Agency Exhibits

A. Appeal Summary (91 pages)

B. Exhibit - County (4 pages)