

STATE HEARING DECISION

ODHS 4005 (Rev. 9/94)

County CUYAHOGA	District Hearings Section CLEVELAND	Assistance Group Name		Assistance Group Number
Place of Hearing CUYAHOGA CDHS	Initial Hearing Date 12/07/2004	Rescheduled Postponed to 12/09/2004	Rescheduled Postponed to	Rescheduled Postponed to

Appellant/Representative	Appellant Representation
	Local Agency Representation Mary Foster, SSC 7332

Date Notice Mailed 10/19/2004	Date Received by Local Agency	Date Received by ODHS 11/01/2004	Date Appeal Summary Received 11/23/2004	Date Scheduling Notice Mailed 11/24/2004
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Appeal Number(s)/Program(s) 1199293/MED

Notice to Appellant

This is the state hearing decision in your case. All papers and materials introduced at the hearing or otherwise filed make up the hearing record. The hearing record will be maintained by the Ohio Department of Job and Family Services.

If you believe this state hearing decision is wrong, you may request an administrative appeal by writing to: Ohio Department of Job and Family Services, Office of Legal Services, 30 East Broad Street, 31st Floor, Columbus, Ohio 43215-3414 or FAX (614) 728-9574. Your request should state why you think the hearing decision is wrong. You can complete the appeal request form included with this decision. Your written request or appeal form must be received by the Office of Legal Services within 15 calendar days from the date this decision is issued. *(If the 15th day falls on a weekend or holiday, this deadline is extended to the next work day.)* During the 15-day administrative appeal period you, or your representative, may request a free copy of the hearing record and recording of the hearing by calling the Bureau of State Hearings at 1-866-635-3748 (select option 1 from main menu).

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association, toll free, at 1-800-589-5888, for the local number.

ISSUE:

Appeal # 1199293:

Medicaid for the Disabled (MA D) benefits may be terminated if the Appellant does not verify all eligibility factors. The Cuyahoga County Department of Job and Family Services (Agency) proposed the termination of Medicaid for the Disabled (MA D) benefits, effective 11/30/04, because all eligibility factors had not been verified. Is the proposed termination correct?

The proposed termination is correct because Appellant has not returned the medical packet for submission to CMS and has not verified all eligibility factors. The appeal is **OVERRULED**.

PROCEDURAL MATTERS:

Notice of adverse action was issued 10/19/04. The state hearing request was received in the Bureau of State Hearings (BSH) 11/01/04 and scheduled for 11/23/04. The state hearing was rescheduled, per Appellant request, and heard 12/09/04. The state hearing scheduling notice was issued to all parties 11/24/04. The

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Appeal(s) OVERRULED 1199293	Date Issued 01/10/2005	Compliance
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Distribution: Original to appellant, one copy to local agency; one copy to district Hearing section; one copy to district office; two copies to State Hearings. *(Photocopy to appellant's authorized representative, if any, and to ODHS units as appropriate.)*

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self-sufficiency coach (SSC) was the representative for the Agency. Appellant represented himself at the appeal. The state hearing was conducted as a telephone hearing. The Appeal Summary was received 11/23/04. The state hearing request was timely and the MA D benefits remained intact pending the state hearing decision.

FINDINGS OF FACT:

1. Appellant had been determined eligible for Medicaid for the Disabled (MA D) benefits effective 10/01/03.
2. A reapplication appointment was held on 09/12/04 with a new eligibility worker who determined that there was no supportive documentation of eligibility for MA D benefits.
3. Appellant was issued the medical packet and the Application Follow-Up Notice on 09/21/04 with a 10/01/04 due date (Exhibit A).
4. The medical packet was not returned and the Medicaid pre-termination notice (PTR) was issued to Appellant 10/18/04 with a 10/28/04 due date (Exhibit A).
5. A medical packet has not been completed for submission to County Medical Services (CMS) because the medical forms have not been received by the Agency.
6. Appellant's own testimony indicates he did not respond to the PTR notice and did not return the medical forms issued by the Agency.
7. Appellant previously had Kaiser Medical coverage which has been terminated. Appellant indicated that it was difficult to obtain medical information from Kaiser.
8. Appellant did not request assistance from the Agency in obtaining medical documentation.
9. Appellant was determined not disabled by the Social Security Administration. Appellant has an Administrative Appeal hearing with the Social Security Administration on 01/14/05.
10. Appellant is alleging arthritis, bursitis, tendonitis, carpal tunnel and major depression as disabling conditions.
11. A review of the County Auditor's Web site on 11/17/04 reflects that Appellant owns a rental home in Lakewood, Ohio, which was not reported to the Agency.
12. Notice requesting verification of the rental property was issued 11/17/04, subsequent to the 11/01/04 state hearing request (Exhibit A).
13. Verification of the rental property was submitted to the Agency on 11/29/04.
14. Further review of Appellant's application indicates Appellant receives dividends from numerous stocks and bonds which were not reported to the Agency or verified. The resource information was discovered 12/07/04.
15. Appellant acknowledged that the rental property and the stocks and bonds were not reported to the Agency because he misunderstood the process.
16. Appellant was authorized for Food Stamp (FS) benefits on 09/21/04.
17. The Food Stamp (FS) benefits were not an issue at the appeal.

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CONCLUSIONS OF POLICY:**Policy**

In order to be eligible for Medicaid, a person must be a member of a covered group and must meet all other eligibility factors for Medicaid. Individuals who meet all other eligibility criteria but are not a member of a covered group are not eligible for Medicaid. Eligibility for Medicaid is determined on an individual basis, i.e., each person is to be determined eligible or ineligible according to the eligibility requirements for the various categories of Medicaid assistance. The specific eligibility requirements for individuals who are aged, blind or have a disability are defined in Chapter 5101:1-39 of the Administrative Code.

No person may receive Medicaid unless all eligibility factors are met. Neither the CDJFS nor the ODJFS shall provide Medicaid to a person merely because of an agency error or delay in processing a person's case, unless all eligibility factors are met. Ohio Admin. Code § 5101:1-37-01 (B&C) (Anderson's 2002)

The AG is responsible for cooperating in the reapplication process. When a face-to-face interview is required, the AG is responsible for answering all relevant questions and providing the necessary verifications to establish continued eligibility. For the AGs identified in paragraph (H)(2) of this rule, a face-to-face interview is not required, however, they are required to provide the necessary verifications to establish continued eligibility. Upon request from the AG, the CDJFS shall provide assistance when the AG is not able to obtain requested information. Failure to verify occurs when the CDJFS properly requests verification which is not provided and the CDJFS is not given necessary information to assist in obtaining the verification needed to determine whether eligibility for assistance continues. Ohio Admin. Code § 5101:1-38-01 (J) (Anderson's 2003)

Limiting physical factor is a basic eligibility requirement in the Medicaid program. The "limiting physical factor" means the applicant/recipient must be sixty-five years of age or older, blind or disabled. These physical factors are considered limiting to the extent that they usually preclude employment. Limiting physical factor must be met by age, blindness or disability. In order for the limiting physical factor to be met by disability, the individual must:

- (1) Be in receipt of RSDI or SSI (based on the individual's own disability); or
- (2) Be determined presumptively disabled by the CDJFS as stated in rule 5101:1-39-03.1 of the Administrative Code; or
- (3) Have an SSI claim pending and be determined eligible by the county medical services section (CMS) as stated in rule 5101:1-39-03.2 of the Administrative Code. Ohio Admin. Code § 5101:1-39-03 (A) (Anderson's 2002)

If a member of an assistance group has, appears to have, or alleges to have a physical or mental condition

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which may limit their ability to work, the CDJFS shall begin developing the medical information necessary for submission to the county medical services section (CMS) for a determination of disability. All applicants who appear potentially eligible for Medicaid who do not otherwise meet the limiting physical factor requirement as stated in rules 5101:1-39-03 and 5101:1-39-03.1 of the Administrative Code shall be referred to the CDJFS to have a medical determination made by CMS. Additionally, all applicants/ recipients pending an SSI determination must be referred to the CMS. If the CMS determines that the limiting physical factor requirement exists, Medicaid shall be approved if all other eligibility requirements are met. If an individual receives a final decision from SSA denying SSI, the CDJFS shall propose termination of Medicaid; however, no attempt shall be made to recover Medicaid payments made on behalf of the recipient as a result of the CMS determination.

The CMS will determine disability for applicants/recipients who meet the following criteria:

- (a) Individuals denied SSI for a reason other than lack of disability;
- (b) Individuals under age sixty-five who die prior to applying for SSI;
- (c) Individuals under age sixty-five who die with an SSI determination pending;
- (d) Individuals pending an SSI determination;
- (e) Individuals who have been determined presumptively disabled by SSI;
- (f) Individuals who claim to be disabled to whom the applicant/recipient wants to transfer assets in accordance with the provisions in Administrative Code rule 5101:1-39-07.

The determination of disability by CMS is based upon the SSI requirements specified in 20 CFR 416.901 to 416.998. Ohio Admin. Code § 5101:1-39-03.2 (A) (1-3) (Anderson's 2002)

Analysis

The evidence presented by the Agency supported that the Appellant was determined eligible for Medicaid for the Disabled (MA D) benefits effective 10/01/03 without substantive documentation of disability. Given the preponderance of the evidence and testimony submitted at the appeal, the Hearing Officer finds that the Medicaid eligibility for the Appellant was approved in error. The error was discovered during the Appellant's 09/21/04 reapplication appointment.

According to the Administrative Code, applicants are responsible for cooperating in the reapplication process and providing the necessary verifications to establish continued eligibility. Failure to verify occurs when the CDJFS properly requests verification which is not provided and the CDJFS is not given necessary information to assist in obtaining the verification needed to determine whether eligibility for assistance continues. The Agency issued the Appellant, and he acknowledged receiving, a basic medical packet in order to determine Medicaid eligibility. The evidence supports that the Appellant failed to provide a completed medical packet for submission to County Medical Services (CMS) for a disability determination. Because the Appellant has not returned said medical packet, the Agency issued the appropriate Application Verification

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Request Checklist, Follow-Up and PTR Notices to Appellant. Given the fact that the Appellant did not respond to the PTR Notice and did not provide the required medical documentation for submission to County Medical Services (CMS) for a disability determination, the Hearing Officer finds the preponderance of the evidence supports that the Appellant failed to cooperate in the application/reapplication process. Therefore, the proposed termination of Medicaid for the Disabled (MA D) benefits is correct.

HEARING OFFICER'S RECOMMENDATIONS:

Appeal # 1199293 - The appeal is OVERRULED. The proposed termination of Medicaid for the Disabled (MA D) benefits, effective 11/30/04, is affirmed.

FINAL ADMINISTRATIVE DECISION AND ORDER:

Finding the hearing officer's decision to be supported by the evidence, the recommendations above are adopted.

EXHIBITS

Exhibit A: Appeal Summary (12)

Exhibit B: Appellant documentation (21)

Date Issued: 01/10/2005