5101:1-39-24 **Medicaid: determining patient liability.**

(A) This rule defines how income is treated for purposes of determining patient liability for individuals receiving long term care services in a long term care facility, under a home and community-based services (HCBS) waiver program, or under the program of all-inclusive care for the elderly (PACE).

(B) Definitions.

(1) "Administrative agency" is the county department of job and family services, the Ohio department of job and family services (ODJFS), or other entity that determines eligibility for a medical assistance program.

(2) "Community spouse" is an individual who is not in a medical institution or nursing facility and has an institutionalized spouse, except that neither of two spouses, married to each other, who both request or receive services under an HCBS waiver program or PACE is considered to meet this definition.

(3) The "excess shelter allowance (ESA)" is the ESA standard minus the community spouse's expenses for the principal place of residence, including: rent or mortgage payment (including principal and interest), taxes and insurance, any required maintenance charge for a condominium or cooperative, and, if applicable, the established standard utility allowance.

(4) The "excess shelter allowance standard" is thirty per cent of the minimum monthly maintenance needs allowance (MMMNA) standard.

(5) "Family allowance" is a deduction in the computation of patient liability, for needs of family members residing with a community spouse. The family allowance, calculated separately for each family member, is one-third of the MMMNA standard, less the gross amount of the monthly income of the family member, then rounded down.

(6) The "family allowance need standard" is one-third of the MMMNA. The family allowance need standard is adjusted annually in accordance with the federal poverty level (FPL).

(7) "Family maintenance needs allowance" is a deduction in the computation of patient liability, for needs of the family members when there is no community spouse. The family maintenance needs allowance is the family maintenance needs allowance standard, less the gross combined monthly income of the family members, then rounded down to the nearest dollar.

(8) The "family maintenance needs allowance standard" is the Ohio works first payment standard for the same number of applicable dependent family members.

(9) A "family member" is:

(a) A natural, adoptive, or step-child or parent or sibling of the individual; who,

(b) Resided in the same household as the individual until the individual's beginning date of institutionalization, or, for HCBS individuals, resides with the waiver eligible individual; and,

(c) Is claimed as a dependent by the individual, the couple, or the community spouse for federal tax purposes for the most recent tax year, or, if a tax return was not filed, could have been claimed as a dependent.

(10) The "federal poverty level (FPL)" is a set of guidelines, issued each year by the United States department of health and human services (HHS), as a poverty measure for administrative purposes such as determining financial eligibility for certain federal programs.

(11) "Home and community-based services (HCBS)" are defined in accordance with rule 5101:1-38-01.6 of the Administrative Code.

(12) "HCBS waiver agency" is the ODJFS, or its designee that performs administrative functions related to an HCBS waiver program, in accordance with rule 5101:1-38-01.6 of the Administrative Code and division-level designation 5101:3 of the Administrative Code.

(13) An "individual" is an applicant for or recipient of medicaid.

(14) "Institutionalized" describes an individual who receives long term care services either in a long term care facility, under an HCBS waiver program, or under PACE for at least thirty consecutive days.

(15) A "long term care facility (LTCF)" is a medicaid-certified nursing facility, skilled nursing facility, or intermediate care facility for persons with mental retardation as defined in division-level designation 5101:3 of the Administrative Code.

(16) "Long term care services" are medicaid-funded, institutional or community-based, medical, health, psycho-social, habilitative, rehabilitative, and/or personal care services that may be provided to medicaid-eligible individuals, as defined in rule 5101:3-3-15 of the Administrative Code.

(17) The "maximum monthly maintenance needs allowance (MaxMMNA)" is a cap on the monthly maintenance needs allowance.

(18) "Medicaid cost of care" is:

(a) For an individual in a LTCF, the daily medicaid per diem rate for each

LTCF; or,

(b) For an individual receiving services under an HCBS waiver program, the medicaid cost of care for waiver-approved services in accordance with the individual's plan of care, or,

(c) For an individual receiving services under PACE, the PACE capitated rate.

(19) The "minimum monthly maintenance needs allowance (MMMNA)" is the MMMNA standard plus the excess shelter allowance (ESA).

(20) The "minimum monthly maintenance needs allowance standard" is one hundred fifty per cent of the federal poverty level (FPL) for a family unit of two members.

(21) "Monthly income allowance" for a community spouse is a deduction in the computation of patient liability for needs of the community spouse. The monthly income allowance is the MMMNA minus the community spouse's monthly income.

(22) "Patient liability" is the individual's financial obligation toward the medicaid cost of care.

(23) "Personal needs allowance" is a required deduction in the computation of patient liability, for needs of the individual. The personal needs allowance for individuals who request or receive services under an HCBS waiver program is referred to as a "special individual maintenance needs allowance." Personal needs allowance retained beyond the month of allocation is treated as a resource and subject to resource requirements of Chapter 5101:1-39 of the Administrative Code.

(24) "Program of all-inclusive care for the elderly (PACE)" is a medicaid program, approved by the centers for medicare and medicaid services (CMS), for certain elderly individuals.

(25) The "special income level" is an amount, in accordance with rule 5101:1-39-21 of the Administrative Code, equal to three hundred per cent of the current supplemental security income (SSI) payment standard for an individual.

(26) The "special individual maintenance needs allowance" is a required deduction in the computation of patient liability, for needs of the individual who requests or receives HCBS under an HCBS waiver program in accordance with rule 5101:1-38-01.6 of the Administrative Code, or for the needs of the individual living in a community setting who requests or receives services under the program of all-inclusive care for the elderly (PACE). The special individual maintenance needs allowance is sixty-five per cent of the special

income level, in accordance with rule 5101:1-39-21 of the Administrative Code.

(27) A "spouse" is a person legally married under Ohio law.

(28) The "standard utility allowance" is an amount that is used in lieu of the actual amount of utility costs, applicable if the community spouse is responsible for payment toward the cost of gas, electric, coal, wood, oil, water, sewage, or telephone for the residence.

(C) Administrative agency responsibilities.

(1) The administrative agency shall determine medicaid eligibility in accordance with the eligibility rules contained in Chapters 5101:1-37 to 5101:1-42 of the Administrative Code,

(2) The administrative agency shall determine the individual's patient liability by utilizing the following procedure, in sequence, subsequent to notification of an appropriate level of care, and, if applicable, HCBS waiver agency approval or PACE site approval:

(a) Total all income, earned and unearned, of the individual, without applying any exemptions or disregards; then,

(b) Exclude the following as income for the purposes of determining patient liability:

(i) German reparation payments, Austrian social insurance payments, and Netherlands reparation payments, in accordance with the Nazi Persecution Victims Eligibility Act (P.L. 103-286) or provisions of the Austrian General Social Insurance Act, paragraphs 500 through 506.

(ii) Japanese and Aleutian restitution payments, under the provisions of Section 105 of Public Law 100-383 by individuals of Japanese ancestry.

(iii) Agent Orange settlement payments under the provisions of the Agent Orange Compensation Exclusion Act (Public Law 101-201) received on or after January 1, 1989.

(iv) Radiation exposure compensation payments under the provisions of the Radiation Exposure Compensation Act (Public Law 101-426).

(v) Veterans Administration pensions limited to ninety dollars per month under 38 USC 5503.

(vi) Seneca nation settlement act of 1990 payments under the provisions of the Seneca Nation Settlement Act of 1990 (Public Law 101-503) received on or after November 3, 1990.

(vii) SSI benefits received under authority of sections 1611(e)(1)(E) and (G) of the SSA (Public Law 100-203 Omnibus Budget Reconciliation Act of 1987), for institutionalized individuals, during the first three full months of institutionalization. The administrative agency shall not retroactively redetermine patient liability determinations made under the continued benefit provision if the recipient's actual stay exceeds the expected stay of ninety days or less.

(viii) Residential state supplement (RSS) benefits to institutionalized individuals, in accordance with rule 5101:1-17-05 of the Administrative Code.

(ix) Payments received under the provisions of the "Ohio Victims of Crime Program."

(x) Cost-of-living subsidies, including, but not limited to, start-up funds and one-time or other housing allowances, provided by Ohio department of mental retardation and developmental disabilities (ODMR/DD) or county boards of mental retardation and developmental disabilities to individuals enrolled in a medicaid waiver administered by the ODMR/DD pursuant to section 5111.871 of the Revised Code.

(xi) Payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corporation, et al, 96-C-5024 (N.D. Ill).

(xii) Payments made from any fund established pursuant to a class action settlement in the case of "Factor VIII or IX concentrate blood products litigation," MDL986 (no. 93--C-7452, (N.D. Ill).

(xiii) In the case of an individual who has no spouse, other than a child under age twenty-one, only the income of that individual is considered in the patient liability determination.

(xiv) For the month following the month of institutionalization, the child is treated as an individual living alone. The child's own income is considered in the patient liability determinations.

(xv) Spouses separated by a continuous period of institutionalization are considered to be living apart starting in the month the

institutionalized spouse enters the institution. Only the income allocated to the institutionalized spouse is considered available in the patient liability determination.

(xvi) Effective through December 31, 2005, neither the six-hundred dollar credit nor any discount savings arising from the medicare-approved drug card shall be counted as income in the patient liability budget process.

(c) The administrative agency shall subtract the appropriate personal needs allowance for the needs of the individual. Appropriate personal needs allowances are:

(i) For individuals who are nursing facility or ICF-MR residents and have no earned income: forty dollars;

(ii) For individuals who are nursing facility or ICF-MR residents and have earned income: forty dollars plus up to an additional sixty-five dollars of gross earnings received as a result of employment, up to a combined maximum of one hundred five dollars;

(iii) For individuals in receipt of veteran's benefits paid under Public Law 95-588 who reside in a long term care facility, do not have a community spouse and/or dependent family members, and have no earned income: ninety dollars;

(iv) For individuals in receipt of veteran's benefits paid under Public Law 95-588 who reside in a long term care facility, do not have a community spouse and/or dependent family member(s), and have earned income: ninety dollars plus up to an additional fifteen dollars of gross earnings received as a result of employment, up to a combined maximum of one hundred and five dollars;

(v) For individuals in receipt of veteran's benefits paid under Public Law 95-588 who are surviving spouses residing in a long term care facility, with no dependent children, and have no earned income: ninety dollars;

(vi) For HCBS waiver eligible individuals who have no earned income: the special individual maintenance needs allowance;

(vii) For HCBS waiver eligible individuals who receive earnings from employment: the special individual maintenance needs allowance plus gross earnings received as a result of employment, up to a maximum of sixty-five dollars above the special individual maintenance needs allowance.

(d) The administrative agency shall compute and subtract a monthly income allowance for the individual's community spouse, if applicable, utilizing the following steps, except in the case that two spouses, married to each other, are both eligible for and receiving services under an HCBS waiver program or PACE:

(i) Total housing expenses of the community spouse: rent, mortgage payment (including principal and interest), taxes and insurance, condominium or cooperative required maintenance charges, and (if applicable) the established standard utility allowance, rounding the total down to the nearest whole dollar; then,

(ii) Subtract the excess shelter allowance standard;

(iii) The remainder is the excess shelter allowance (ESA);

(iv) Add the ESA and the MMMNA standard to determine the MMMNA; then,

(v) Subtract the community spouse's total gross income;

(vi) The remainder, up to the amount of the maximum monthly maintenance needs allowance (rounded down to the nearest whole dollar), is the monthly income allowance for the community spouse, unless:

(a) The amount of court ordered spousal support is greater, in which case the court ordered amount is used as the monthly income allowance; or,

(b) Through the ODJFS hearing process, the monthly maintenance needs allowance is increased in accordance with rule 5101:6-7-02 of the Administrative Code.

(vii) The monthly income allowance from an institutionalized individual to a community spouse who is either an HCBS waiver-eligible individual or a PACE eligible individual shall be treated as unearned income to the community spouse in the determination of medicaid eligibility and patient liability.

(e) The administrative agency shall compute and subtract, if applicable, a family allowance for each family member, utilizing the following steps: An institutionalized spouse and an HCBS waiver eligible spouse or a PACE eligible spouse, married to each other, the family allowance shall be deducted in the patient liability calculation of only one of the individuals. The family allowance provided from the institutionalized

spouse shall be treated as unearned income.

(i) For each family member, multiply the MMMNA standard by one-third; then,

(ii) Subtract that family member's gross monthly income; then

(iii) Round the result down to the nearest dollar.

(iv) The remainder is the family allowance for that family member.

(v) The family allowances for each family member are added together to determine the total family allowance.

(f) The administrative agency shall compute and subtract, if applicable, a family maintenance needs allowance utilizing the following steps:

(i) Subtract the combined monthly income of the family members from the family maintenance needs allowance standard; then,

(ii) Round the result down to the nearest dollar.

(iii) The remainder is the family maintenance needs allowance.

(g) The administrative agency shall subtract the individual's medical expenses that are not subject to third party payment, including:

(i) Medicaid, medicare, or other health insurance premiums;

(ii) Insurance deductibles, coinsurance, or copayments;

(iii) Necessary medical or remedial care, recognized under Ohio law, but not covered by medicaid and not subject to third party payment;

(iv) Remedial/recurring medical expenses; and

(v) Unpaid past medical expenses.

(h) The remainder is the individual's patient liability for a full month of institutionalization.

(i) The administrative agency shall prorate the patient liability when the individual is institutionalized for less than a full month. To calculate a prorated patient liability, the administrative agency shall:

(i) Determine the per diem patient liability by dividing the patient

liability for a full month of institutionalization by the number of days in the month for which the prorated payment is to be determined.

(ii) Determine the actual number of days of institutionalization in the month for which the prorated payment is to be determined, including the first date of institutionalization and the last date of institutionalization.

(iii) Multiply the actual number of days of institutionalization by the per diem amount, rounding down to the nearest dollar. This is the individual's prorated patient liability.

(3) The administrative agency shall recalculate the patient liability when notified of changes that may affect the patient liability amount.

(4) The administrative agency shall notify the institution, HCBS waiver agency, or PACE site of the patient liability, changes to patient liability, and retroactive patient liability adjustments.

(5) The administrative agency shall provide written notification to the individual of the determination of medical assistance eligibility and the amount of patient liability, if applicable.

(6) The administrative agency shall issue proper notice and hearing rights as outlined in division level designation 5101:6 of the Administrative Code.

(D) The individual shall pay the patient liability amount to the entity as directed.

(E) The long term care facility shall:

(1) Accept the patient liability amount from the individual.

(2) Refund overpayments of patient liability to the individual, such as when retroactive patient liability adjustments are made.

(F) The HCBS waiver agency shall notify the individual as to whom to make patient liability payment.

(G) The PACE site shall notify the individual as to whom to make patient liability payment.

(H) The ODJFS shall provide appropriate notice to the individual, and the individual's community spouse, if applicable, including the monthly income allowance (MIA) and appeal rights, the amounts deducted in the calculation of patient liability, and the determination of ownership and availability of income.

Replaces: 5101:1-39-22.2, 5101:1-39-95, 5101:1-39-22.1, 5101:1-39-22.3, 5101:1-39-22.4, 5101:1-39-22.6, 5101:1-39-12, 5101:1-39-85, and 5101:1-39-26.1

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