TO BE RESCINDED

5160:1-3-04.3 **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 medical institution, 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) "Authorized representative" has the same meaning as in rule 5160:1-1-50.1 of the Administrative Code.

(2) "Community spouse" means an individual who is not in a nursing facility or medical facility for receipt of long term care services and has an institutionalized spouse. This includes an individual requesting or receiving services under an HCBS waiver program or PACE whose spouse is institutionalized in a medical institution or nursing facility. Neither of two spouses, married to each other, who both request or receive services under an HCBS waiver program or PACE is considered a community spouse.

(3) The "excess shelter allowance" (ESA) means 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, minus the ESA standard.

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

(5) "Family allowance" means a deduction in the computation of patient liability for the needs of dependent family members, described in paragraph (B)(9)(a) of this rule, who are residing with the 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 to the nearest whole dollar.

(6) The "family allowance need standard" means 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" means a deduction in the computation of patient liability for the needs of dependent family members, described in

paragraph (B)(9)(b) of this rule, when there is no community spouse. The family maintenance needs allowance is the family maintenance needs allowance standard for the total number of dependent family members, less the gross combined monthly income of the family members, then rounded down to the nearest dollar.

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

(9) "Family member" means a natural, adoptive, or step-child or parent or sibling of the individual who:

(a) For the purpose of determining a family allowance:

(i) Is claimed as a dependent by the institutionalized spouse, the community spouse, or the couple, for the most recent federal tax year, or, if a tax return was not filed, could be claimed as a dependent; and

(ii) Is residing with the community spouse.

(b) For the purpose of determining a family maintenance needs allowance:

(i) Is claimed as a dependent by the institutionalized individual for the most recent tax year, or, if a tax return was not filed, could be claimed as a dependent; and

(ii) Has resided with the institutionalized individual immediately preceding the institutionalized individual's admission to the nursing facility or is residing with the individual who is enrolled in an HCBS waiver or PACE.

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

(11) "Financially responsible relative," for the purpose of this rule, means the individual's spouse or, if the individual is a minor or disabled child, the individual's parent.

(12) "Home and community-based services" (HCBS) are defined in accordance with rule 5160:1-1-50.1 of the Administrative Code.

(13) "HCBS waiver agency" means ODM or its designee that performs administrative functions related to an HCBS waiver program, in accordance with rule 5160:1-2-01.6 of the Administrative Code and Chapter 5160-3 of the Administrative Code.

(14) "Institutionalized", for the purpose of this rule, describes an individual who receives long term care services in a medical institution, a long term care facility, intermediate care facility for individuals with intellectual disabilities (ICF-IID), under an HCBS waiver program, or under PACE.

(15) "Institutionalized spouse" means an individual who:

(a) Receives long term care services in a medical institution, a long term care facility, ICF-IID, under an HCBS waiver program, or under PACE for at least thirty consecutive days; and

(b) Is married to a spouse who is not in a nursing facility or medical facility for receipt of long term care services.

(16) A "long-term care facility" (LTCF) means a medicaid-certified nursing facility, skilled nursing facility, or intermediate care facility for individuals with intellectual disabilities as defined in rule 5160-3-01 of the Administrative Code.

(17) "Long-term care services" mean 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 5160-3-05 of the Administrative Code.

(18) "Medicaid cost of care" means:

(a) For an individual in a LTCF, the 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) means the MMMNA standard plus the excess shelter allowance (ESA).

(a) Except in accordance with rule 5101:6-7-02 of the Administrative Code, the MMMNA must not exceed the MMMNA cap which is updated annually by the same percentage increase in the consumer price index.

(b) The MMMNA may be increased in accordance with rule 5101:6-7-02 of the Administrative Code.

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

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

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

(23) "Personal needs allowance" (PNA) means a required deduction in the computation of patient liability for needs of the individual. The PNA for individuals who request or receive services under an HCBS waiver program is referred to as the "special individual maintenance needs allowance." PNA funds retained beyond the month of allocation are treated as a resource and are subject to resource requirements of Chapter 5160:1-3 of the Administrative Code.

(24) "Plan of care" means the written document that specifies the HCBS waiver and other services (regardless of funding source) along with any informal supports that are furnished to meet the needs of and to assist a waiver participant to remain in the community. The plan contains, at a minimum, the types of services to be furnished, the amount, the frequency and the duration of each service and the type of provider to furnish each service.

(25) "Program of all-inclusive care for the elderly" (PACE) means the medical assistance program set forth in 42 C.F.R. 460 (as in effect on October 1, 2014).

(26) The "special income level" means an amount equal to three hundred per cent of the current supplemental security income (SSI) payment standard for an individual, as published annually by the social security administration.

(27) The "special individual maintenance needs allowance" (SIMNA) means 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 5160:1-2-03 of the Administrative Code, or for the needs of the individual living in a community setting who requests or receives services under PACE. The SIMNA is sixty-five per cent of the special income level.

(28) A "spouse" means a person legally married to another under Ohio law.

(29) The "standard utility allowance" means an amount that is used in lieu of the actual amount of utility costs. The standard utility allowance is 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 must determine medicaid eligibility in accordance with the eligibility rules contained in Chapters 5160:1-1 to 5160:1-6 of the Administrative Code.

(2) The administrative agency must 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, Pub. L. No. 103-286 or provisions of the Austrian General Social Insurance Act, paragraphs 500 through 506 (as in effect January 1, 2014).

(ii) Japanese and Aleutian restitution payments, under the provisions of section 105 of Pub. L. No. 100-383 (as in effect January 1, 2014), by individuals of Japanese ancestry.

(iii) Agent Orange settlement payments under the provisions of the Agent Orange Compensation Exclusion Act, Pub. L. No. 101-201 (as in effect January 1, 2014), received on or after January 1, 1989.

(iv) Radiation exposure compensation payments under the provisions of the Radiation Exposure Compensation Act, Pub. L. No. 101-426 (as in effect January 1, 2014).

(v) Veterans administration pensions, up to the amount of ninety dollars per month, paid to veterans in a nursing facility or receiving HCBS waiver services. This exclusion applies to:

*(a)* A veteran without a spouse or dependent minor or disabled child; and

*(b)* A veteran's surviving spouse without a dependent minor or disabled child.

(vi) Seneca nation settlement act of 1990 payments under the provisions of the Seneca Nation Settlement Act of 1990, Pub. L. No. 101-503 (as in effect January 1, 2014), received on or after November 3, 1990.

(vii) SSI benefits received under authority of sections 1611(e)(1)(E) and (G) of the SSA, Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203 (as in effect January 1, 2014), for institutionalized individuals, during the first three full months of institutionalization. The administrative agency must 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 Chapter 5101:1-17 of the Administrative Code.

(ix) Payments received under the provisions of a state "Victims of Crime Program", Pub. L. No. 103-322 (as in effect January 1, 2014), for a period of nine months beginning with the month following the month of receipt.

(x) Cost-of-living subsidies, including, but not limited to, start-up funds and one-time or other housing allowances, provided by the Ohio department of developmental disabilities (DODD) or county boards of developmental disabilities to individuals enrolled in a medicaid waiver administered by the DODD pursuant to section 5166.21 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), per section 4735 of the Balanced Budget Act of 1997, Pub. L. No. 105-33 (as in effect January 1, 2014).

(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), per section 4735 of the Balanced Budget Act of 1997, Pub. L. No. 105-33 (as in effect January 1, 2014).

(xiii) In the case of an individual who has no spouse, only the income of that individual is considered in the patient liability determination.

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

(xv) Spouses separated by a continuous period of institutionalization as defined in rule 5160:1-3-06.1 of the Administrative Code 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.

(c) Subtract the appropriate monthly personal needs allowance for the needs of the individual. Appropriate personal needs allowances are:

(i) For individuals who are institutionalized in a medical institution or a nursing facility and have no earned income:

*(a)* Forty-five dollars during calendar year 2014; and

*(b)* Fifty dollars during calendar year 2015 and each calendar year thereafter.

(ii) For individuals who are institutionalized in a medical institution or a nursing facility and have earned income:

*(a)* Forty-five 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 ten dollars during calendar year 2014; and

*(b)* Fifty 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 fifteen dollars during calendar year 2015 and each calendar year thereafter.

(iii) For individuals who are ICF-IID residents and have no earned income:

*(a)* Forty dollars during calendar year 2015; and

*(b)* Fifty dollars during calendar year 2016 and each calendar year thereafter.

(iv) For individuals who are ICF-IID residents and have earned income:

*(a)* 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 during calendar year 2015; and

*(b)* Fifty dollars plus up to an additional sixty-five dollars of gross earning received as a result of employment, up to a combined maximum of one hundred fifteen dollars during calendar year 2016 and each calendar year thereafter.

(v) For individuals eligible for an HCBS waiver or PACE who have no earned income: the SIMNA;

(vi) For individuals eligible for an HCBS waiver or PACE who have earned income: the SIMNA plus up to an additional sixty-five dollars of gross earnings received as a result of employment.

(d) Compute and subtract a MIA 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 a 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 (this amount must not exceed the cap on the MMMNA);

(v) Subtract the community spouse's total gross income from the lesser of the MMMNA or the cap on the MMMNA;

(vi) The remainder, rounded down to the nearest whole dollar, is the MIA for the community spouse, unless the amount of court ordered support is greater, in which case the court ordered amount is used as the MIA.

(vii) All available income of the institutionalized spouse must be transferred to the community spouse and determined insufficient to meet the MIA before a substituted community spouse resource allowance is considered in accordance with rule 5101:6-7-02 of the Administrative Code.

(viii) The MIA from an institutionalized individual to a community spouse who is either an HCBS waiver-eligible individual or a PACE-eligible individual must be treated as unearned income to the community spouse in the determination of eligibility for medical assistance and patient liability.

(e) 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 must be deducted in the patient liability calculation of only one of the individuals. The family allowance provided from the institutionalized spouse must 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) 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) Subtract the following medical costs incurred by the individual or financially responsible relatives:

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

(ii) Insurance deductibles, coinsurance, or copayments;

(iii) Unpaid past medical expenses for medically necessary services, excluding cost of care already used to meet the individual's spenddown.

(h) Deduct the cost of any of the individual's incurred expenses for medical care, recognized under Ohio law, but not covered by medicaid and not subject to third-party payment. The expenses, and any request to deduct such expenses from the patient liability, must meet the following criteria:

(i) The service must have been medically necessary as determined by ODM.

(ii) The service must have been provided by a provider with a valid medicaid provider agreement at the time of the service delivery.

(iii) The request for the deduction of the incurred expense can only be initiated by either the individual or the individual's authorized representative. A written document signed by the individual or the individual's authorized representative which expresses, with reasonable clarity, a request to have the incurred medical expenses deducted is sufficient. If the document is unclear on what the individual is requesting, the administrative agency must take reasonable steps to contact the individual or the individual's authorized representative to obtain the necessary clarification. If written authorization is not available, verbal communication to a county worker by the individual or the individual's authorized representative is sufficient.

(iv) A request for a deduction cannot be initiated by a medical services provider or supplier.

(v) The amount of the deduction cannot exceed the lesser of: the provider billed charges, the medicaid rate, the lowest rate by "Ohio Federally Facilitated Market Place" plans, or the medicare rate.

(vi) If a deduction cannot be approved, the administrative agency must issue a state hearing notice to the individual informing the individual that the amount cannot be deducted from the patient liability because it does not meet the requirements of this rule.

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

(j) The administrative agency must prorate the patient liability when the individual is institutionalized for less than a full month due to death, discharge from the nursing facility or HCBS waiver or PACE program, or initial intake. To calculate a prorated patient liability:

(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. The date of discharge or the date of death is not included in this calculation.

(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.

(k) When an individual who is already receiving medicaid becomes institutionalized, the administrative agency shall issue proper notice of adverse action before requiring a patient liability.

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

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

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

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

(E) The long-term care facility must:

(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 must notify the individual as to whom to make patient liability payment.

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

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

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

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