CSI - Ohio
The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Job and Family Services

Regulation/Package Title: Medicaid: Determining Patient Liability

Rule Number(s): 5160:1-3-04.3 (N), 5160:1-3-24 (R)

Date: 6/18/15

Rule Type:

- [X] New
- [ ] Amended
- [X] 5-Year Review
- [X] Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

77 SOUTH HIGH STREET | 30TH FLOOR | COLUMBUS, OHIO 43215-6117
CSIOhio@governor.ohio.gov

Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   This regulation sets forth the policies for determining Medicaid patient liability. The regulation was opened in order to: increase the personal needs allowance in accordance with changes to section 5163.33 of the Revised Code adopted under Am. Sub. H.B. 59, 130th G.A.; to change the way cost of care is deducted from the patient liability in certain circumstances; to specify that unpaid past medical bills must have been incurred within the previous 365 days in order to be used to reduce the patient liability; to expand the group of veterans and veterans' widows who have a portion of their veterans administration pension excluded as income in patient liability calculations; to change references in the rule from ODJFS to ODM; and to change citations to Ohio Administrative Code Medicaid rules from 5101 to 5160. The amendments to this regulation do not change this regulation's impact on business. However, the requirements in paragraphs (E), (F) and (G), which are unchanged from previous versions, require Medicaid Providers to participate in the processing of patient liability payments. These requirements result in a minimal business impact to the Medicaid Provider.

2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**

   Ohio Revised Code sections 5160.02, 5163.02.

3. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   If yes, please briefly explain the source and substance of the federal requirement.

   This regulation implements Federal requirements for Medicaid eligibility standards and post-eligibility treatment of income. The regulation is necessary for administration and enforcement of the Medicaid Program. The following regulations are implicated: 42 USC 1396a (state plans for medical assistance), 42 USC 1396b (payment to states of federal match), 42 USC 1396k (assignment, enforcement, and collection of rights of payments for medical care; establishment of procedures pursuant to State plan; amounts retained by State), 42 CFR 435.733 (post-eligibility treatment of income of institutionalized individuals in States using more restrictive requirements than SSI: Application of patient income to the cost of care), 42 CFR 435.735 (post-eligibility treatment of income and resources of individual receiving home and community-based services furnished under a waiver: application of patient income of the cost of care) and 42 CFR 484.10(e) (condition of participation, patient rights: patient liability for payment).

4. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   None. The parts of the regulation triggering this analysis are required and in-line with federal regulations and authority.

5. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   This regulation describes how the Agency determines the amount of income a Medicaid recipient must contribute towards the cost of his/her long-term care services as required by Federal Medicaid law.

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   The successful output/outcome is determined by the compliance of the State of Ohio with Federal Medicaid requirements and making the correct determination of the patient liability for Medicaid recipients. The accuracy of those determinations is ascertainable by periodic Medicaid Eligibility Quality Control (MEQC) audits.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
   If applicable, please include the date and medium by which the stakeholders were initially contacted.

   The draft regulation went through internal pre-clearance review and was then posted on the state clearance website on 12/24/14 for a period of 14 days.

8. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?**

   Stakeholders provided the following input:

   - Agency staff suggested clarifying that medical bills used in the calculation of patient liability must be for medically necessary services. The draft regulation was changed to add the suggested clarification.

- Sister agency staff questioned why individuals in nursing facilities have a higher personal needs allowance than individuals living in intermediate care facilities. This difference is in accordance with language in Amended Substitute House Bill 59; therefore, the draft regulation was not changed.
- An attorney with the elder law community suggested that court-ordered alimony and child support must be deducted when calculating patient liability. This would be inconsistent with federal regulations at 20 CFR 416.1110 and 1123(b) and Ohio Administrative Code rule 5160:1-3-03.1(E); therefore, the draft regulation was not changed.
- The Ohio Association of Area Agencies on Aging suggested that the time limit for using unpaid past medical expenses in the patient liability calculation be extended from 365 days to 18 to 24 months. In this draft regulation, the agency specifies a 365-day time limit on the use of unpaid past medical expenses in the patient liability calculation in order to be consistent with the same time limit within which Medicaid providers must submit claims, and to allow for more consistent cost projections. Therefore, the draft regulation was not changed.

The specific parts of the regulation triggering this analysis generated no comments from stakeholders.

9. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

The use of scientific data is not applicable to the requirements of this rule.

10. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?

This rule is required by Federal law 42 USC 1396a, 42 USC 1396b, 42 USC 1396k, 42 CFR 435.733, 42 CFR 435.735 and 42 CFR 484.10(e). As such, the Agency does not consider alternative regulations appropriate.

11. Did the Agency specifically consider a performance-based regulation? Please explain. Performance-*based regulations define the required outcome, but don't dictate the process* the regulated stakeholders must use to achieve compliance.

No. There are no specific regulations governing the process for Medicaid Providers, other than the provider is required to receive, process, or refund the payments. Performance-based regulation would be inapplicable because Medicaid Providers are given flexibility to develop and use methods to best fit their business models to accomplish the regulation.

12. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

The Agency performed a review of the Ohio Administrative Code. Regulations defining the calculation of patient liability for Ohio Medicaid recipients of long-term care services exist in only two regulations: this rule and in OAC 5160:1-3-04.4 (describes a variation of the patient liability calculation for recipients of the Assisted Living Waiver). Further, under Ohio Revised Code Section 5162.03, the Ohio Department of Medicaid is the single state agency to supervise the administration of the Medicaid program, and under Ohio Revised Code Section 5162.022, the Department's regulations governing Medicaid are binding on other agencies that administer components of the Medicaid program. No agency may establish, by rule or otherwise, a policy governing Medicaid that is inconsistent with a Medicaid policy established, in rule or otherwise, by the medical assistance director.

13. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

The parts of the regulation triggering this analysis do not require the Medicaid Provider to implement anything, as it is already part of the standard business practice of the Medicaid Provider.

Adverse Impact to Business

14. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community;
The target of this regulation is not primarily the business community, but does have a minimal business impact on Medicaid Providers. The Agency, and by extension, the CDJFS will use this regulation to determine patient liability amounts for Medicaid recipients of long-term care services.

b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and

Medicaid providers will expend the same amount of employee time in receiving, processing, and refunding patient liability payments as they currently do. In addition, Ohio's single PACE provider will expend the same amount of employer time informing recipients where to send patient liability payments.

c. Quantify the expected adverse impact from the regulation.
The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a *"representative business." Please include the source for your information/estimated* impact.

This is a minor change to an established business practice; as such, for Medicaid providers, these practices are not new and are a standard part of business. Based on interviews with two providers, the estimated amount of time to receive and process patient liability and to process over-payments is a few hours per month. Similarly, per a discussion with the PACE provider, the estimated amount of time to receive and process patient liability payments range from a few moments for patients who consent to automatic ACH withdrawals of the patient liability, to a few hours for patients who pay patient liability by check.

15. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

The parts of the regulation triggering this analysis were not changed from previous versions. Those sections that create a minimal impact on business required by federal statute and are long-standing standard business practices for Medicaid providers, which includes the cost of compliance to process, receive, or refund payments from the individuals served. The intent of the regulation, as a whole, is to comply with Federal regulation and to ensure continuation of the Medicaid program.

Regulatory Flexibility

16. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

No. When Medicaid recipients are required to pay patient liability (their share of the cost of care) the Medicaid provider has to have the ability to receive, process, and refund those payments. PACE providers also have to inform recipients where to make patient liability payments. If these practices are not done appropriately, and the recipient is found to have paid more than required, a violation of State and Federal law has occurred. For example, see, Ohio Administrative Codes 5160:1-3-24 and 5160:1-3-24.1, 42 CFR 435.733 and 42 CFR 435.735.

There are no specific regulations governing this process, other than the provider is required to receive, process, or refund the payments. As such, Medicaid providers are given flexibility to develop and use methods to best fit their business models to accomplish the regulation.

17. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

This is not applicable since there are no fines or penalties associated with non-compliance.

18. What resources are available to assist small businesses with compliance of the regulation?

Medicaid providers in need of technical assistance can contact Medicaid Provider Assistance at 1-800-686-1516.

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, except that, for the purpose of this rule, it cannot include a provider of a medical service or product that is subject to a determination of medical necessity by the Ohio department of medicaid (ODM) as described in paragraph (C)(2)(h)(i) of this rule for purposes of requesting that the cost of such medical service or product be deducted from the individual's patient liability.

(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 (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 (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 through 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: forty dollars;

(iv) For individuals who are ICF-IID 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;

(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, incurred within the previous three hundred sixty-five days, 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.

Replaces: 5160:1-3-24

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	111.15
Statutory Authority:	5160.02, 5163.02
Rule Amplifies:	5163.33
Prior Effective Dates:	6/1/88 (Emer.), 8/1/88 (Emer.), 10/30/88, 1/1/90 (Emer.), 3/1/90 (Emer.), 3/30/90 (Emer.), 4/1/90, 6/29/90, 7/1/90, 10/1/90, 1/1/91 (Emer.), 4/1/91, 1/1/92 (Emer.), 3/20/92, 5/1/92 (Emer.), 7/1/92, 8/14/92 (Emer.), 11/1/92, 5/1/93, 9/1/93, 7/1/94, 1/1/95 (Emer.), 3/20/95, 10/1/95, 4/1/96, 1/1/97 (Emer.), 2/9/97, 12/31/97 (Emer.), 2/1/98, 4/1/99, 1/1/00, 1/1/01, 5/12/02, 7/01/05, 12/01/06, 11/1/13

TO BE RESCINDED

5160:1-3-24 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) "Community spouse" means an individual who is not in a medical institution or nursing facility 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.

(2) 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.

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

(4) "Family allowance" means a deduction in the computation of patient liability, for needs of certain dependent 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 to the nearest whole dollar.

(5) 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).

(6) "Family maintenance needs allowance" means a deduction in the computation of patient liability for needs of certain dependent family members 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.

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

(8) "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.

(9) The "federal poverty level (FPL)" means 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.

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

(11) "HCBS waiver agency" means 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 5101:3 of the Administrative Code.

(12) "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 the mentally retarded (ICF-MR), under an HCBS waiver program, or under PACE.

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

(a) Receives long term care services in a medical institution, a long term care facility, intermediate care facility for the mentally retarded (ICF-MR), 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 medical institution or a nursing facility.

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

(15) "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 5101:3-3-05 of the Administrative Code.

(16) "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.

(17) 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.

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

(19) "Monthly income allowance" for a community spouse means 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.

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

(21) "Personal needs allowance" means 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.

(22) "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.

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

(24) 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.

(25) The "special individual maintenance needs allowance" 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 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 PACE. The special individual maintenance needs allowance is sixty-five per cent of the special income level, in accordance with rule 5101:1-39-23 of the Administrative Code.

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

(27) 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 5101:1-37 to 5101:1-42 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 on August 1, 1994.

(ii) Japanese and Aleutian restitution payments, under the provisions of section 105 of Pub. L. No. 100-383, as in effect on August 10,

1988, 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 on January 1, 1989, 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 on October 15, 1990.

(v) Veterans administration reduced pensions under 38 U.S.C. 5503, as in effect on November 10, 2005, up to the amount of ninety dollars per month, paid to veterans in a nursing facility. This reduced pension applies to the following individuals:

(a) A veteran without a spouse or child; and

(b) A veteran's surviving spouse without a child.

(vi) The first ninety dollars of veterans administration aid and attendance pensions paid to veterans or their widows who are receiving HCBS waiver services and who have no dependent minor or disabled children.

(vii) 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 on November 3, 1990, received on or after November 3, 1990.

(viii) 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 on December 22, 1987, 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.

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

(x) Payments received under the provisions of a state "Victims of Crime Program", Pub. L. No. 103-322, as in effect on September 13, 1994.

(xi) 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 5111.871 of the Revised Code.

(xii) 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 on August 5, 1997.

(xiii) 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 on August 5, 1997.

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

(xv) 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.

(xvi) 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.

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

(c) The administrative agency must 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 HCBS waiver eligible individuals who have no earned income: the special individual maintenance needs allowance;

(iv) For HCBS waiver eligible individuals who have earned income: the special individual maintenance needs allowance plus up to an additional sixty-five dollars of gross earnings received as a result of employment.

(d) The administrative agency must 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 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 monthly income allowance for the community spouse, unless the amount of court ordered support is greater, in which case the court ordered amount is used as the monthly income allowance.

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

(viii) 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 must be treated as unearned income to the community spouse in the determination of eligibility for medical assistance and patient liability.

(e) The administrative agency must 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) The administrative agency must 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 must subtract the individual's medical expenses 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) Unpaid past medical expenses, excluding cost of care already used to meet the individual's spenddown.

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

(i) 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, the administrative agency must:

(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.

(j) 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 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.

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

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	111.15
Statutory Authority:	5111.01, 5111.011
Rule Amplifies:	5111.01, 5111.011
Prior Effective Dates:	6/1/88 (Emer.), 8/1/88 (Emer.), 10/30/88, 1/1/90 (Emer.), 3/1/90 (Emer.), 3/30/90 (Emer.), 4/1/90, 6/29/90, 7/1/90, 10/1/90, 1/1/91 (Emer.), 4/1/91, 1/1/92 (Emer.), 3/20/92, 5/1/92 (Emer.), 7/1/92, 8/14/92 (Emer.), 11/1/92, 5/1/93, 9/1/93, 7/1/94, 1/1/95 (Emer.), 3/20/95, 10/1/95, 4/1/96, 1/1/97 (Emer.), 2/9/97, 12/31/97 (Emer.), 2/1/98, 4/1/99, 1/1/00, 1/1/01, 5/12/02, 7/01/05, 12/01/06, 1/1/13