5160:1-6-07.1 **Medicaid: post-eligibility treatment of income for individuals receiving services through a home and community-based services (HCBS) waiver or the program of all-inclusive care for the elderly (PACE).**

(A) This rule describes the process for calculating an individual's post-eligibility treatment of income (PETI), commonly referred to as patient liability or share of cost when the individual is not living in a medical institution. This rule only applies to an individual who is both eligible for medical assistance under the special income level (SIL) as described in rule 5160:1-6-03.1 of the Administrative Code and receiving HCBS waiver or PACE services.

(B) The administrative agency will reduce its payment to the HCBS waiver or PACE providers identified in paragraph (C) of this rule for services provided to the individual by the amount of the individual's patient liability calculated in accordance with this rule.

(C) The individual must pay the patient liability amount to his or her providers identified by the HCBS waiver or PACE administrative agency.

(D) Patient liability must be recalculated when there is a change in circumstances that affects the patient liability amount.

(E) Providers are required to refund to the individual any overpayments of patient liability paid by the individual, such as when retroactive patient liability adjustments are made.

(F) For purposes of this rule, the following definitions apply:

(1) "Assisted living waiver maintenance needs allowance (ALMNA)" is an amount equal to the current supplemental security income (SSI) federal benefit rate (FBR).

(2) "Special individual maintenance needs allowance (SIMNA)" is sixty-five per cent of the special income level.

(G) For purposes of this rule, patient liability is calculated in the following order:

(1) Total the individual's gross monthly earned and unearned income, including SSI payments. In the case of an institutionalized spouse, include any income attributed to the institutionalized spouse in accordance with rule 5160:1-6-04 of the Administrative Code.

(2) Exclude the following payments from the individual's gross monthly income:

(a) 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 October 1, 2016).

(b) Japanese and Aleutian restitution payments, under the provisions of section 105 of Pub. L. No. 100-383 (as in effect October 1, 2016), by individuals of Japanese ancestry.

(c) Agent Orange settlement payments under the provisions of the Agent Orange Compensation Exclusion Act, Pub. L. No. 101-201 (as in effect October 1, 2016), received on or after January 1, 1989.

(d) Department of defense payments to certain persons captured and interned in North Vietnam, in accordance with the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act of 1998 (as in effect on October 1, 2016).

(e) Radiation exposure compensation payments under the provisions of the Radiation Exposure Compensation Act, Pub. L. No. 101-426 (as in effect October 1, 2016).

(f) Veterans affairs payments made to or on behalf of:

(i) Certain Vietnam veterans' natural children regardless of or age or marital status, for any disability resulting from spina bifida suffered by such children under provision 421 of Pub. L. No. 104-204 (38 U.S.C. 1805(d); as in effect October 1, 2016);

(ii) Certain Korea service veterans' natural children regardless of their age or marital status, for any disability resulting from spina bifida suffered by such children under provision 102 of the Veterans Benefits Act of 2003, P.L. 108-183 (as in effect October 1, 2016);

(iii) Women Vietnam veterans' natural children regardless of their age or marital status, for certain birth defects under provision 401 of Pub. L. No. 106-419 (38 U.S.C. 1833(c); as in effect October 1, 2016).

(g) 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:

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

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

(h) Payments made to Native Americans as listed in section IV of 20 C.F.R. 416 Subpart K Appendix (as in effect on October 1, 2016).

(i) 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 October 1, 2016), 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.

(j) Residential state supplement (RSS) benefits to institutionalized individuals, in accordance with rule 5160:1-5-01 of the Administrative Code.

(k) Payments received under the provisions of a state "Victims of Crime Program", per 42 U.S.C 10602(c) (as in effect October 1, 2016).

(l) 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 October 1, 2016).

(m) 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 October 1, 2016).

(n) Assistance (other than wages or salaries) under the Older Americans Act of 1965 under 92 Stat. 1515, 42 U.S.C. 3020a (as in effect October 1, 2016).

(o) Student financial assistance from a program funded under Title IV of the Higher Education Act (HEA) of 1965 or Bureau of Indian Affairs (BIA) per the Higher Education Technical Amendments Act of 1987 (20 U.S.C. 1087uu; as in effect October 1, 2016).

(p) Monies in an individual development account (IDA) as provided by the Assets for Independence Act, as amended in 2002 (Pub. L. No. 107-110, 42 U.S.C. 604(h)(4)), listed as exclusion (xxiv) (as in effect October 1, 2016).

(q) Foster care subsidies under title IV-B or title-XX and adoption assistance subsidies under title IV-E per 42 U.S.C. 673(b).

(r) Assistance under the Child Care and Development Block Grant Act of 1990 (20 USC 9858q; as in effect October 1, 2016).

(s) Assistance or services received through the Domestic Volunteer Service under 42 U.S.C. 66 per 42 U.S.C. 5044(f) (as in effect October 1, 2016).

(t) Assistance or services received through the Supplemental Nutrition Act Program per 7 U.S.C. 2017(b); the School Lunch Program per 42 U.S.C. 1760(e); the Child Nutrition Act per 42 U.S.C. 1780(b); and the Nutrition Program for Elderly (Title VII) per 42 U.S.C. 3020a(a) (as in effect October 1, 2016).

(u) Payments made under the Disaster Relief and Emergency Assistance Act per 42 U.S.C. 5155(d) (as in effect October 1, 2016).

(v) Assistance, with respect to the dwelling unit occupied by such individual (or such individual and spouse), under the United States Housing Act of 1937, the National Housing Act, section 101 of the Housing and Urban Development Act of 1965, title V of the Housing Act of 1949, or section 202(h) of the Housing Act of 1959 per 42 U.S.C. 1382a (as in effect October 1, 2016).

(w) Relocation assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 in accordance with 42 U.S.C. 4636 (as in effect on October 1, 2016) provided to individuals displaced by any federal or federally-assisted project or state or local government or through a state-assisted or locally-assisted project in the acquisition of real property.

(x) The first two thousand dollars per calendar year received as compensation for participation in clinical trials that meet the criteria detailed in section 1612(b) of the Social Security Act (Pub. L. 107-110; as in effect October 1, 2016).

(3) Subtract the applicable personal needs allowance (PNA) as follows:

(a) For individuals receiving services under an HCBS waiver, other than the Assisted-Living Waiver, the PNA is the SIMNA. If the individual has earned income, subtract up to an additional sixty-five dollars from the earned income.

(b) For individual receiving services under the Assisted-Living Waiver the PNA is the ALMNA. If the individual has earned income, subtract up to an additional sixty-five dollars from the earned income.

(c) For individuals receiving PACE services and residing in the community, the PNA is the SIMNA.

(d) For individuals receiving PACE services and residing in an assisted-living facility, the PNA is the ALMNA.

(4) If the individual has a community spouse, subtract the monthly income allowance (MIA) for the community spouse.

(a) The MIA of the community spouse is calculated as follows:

(i) Determine the excess shelter allowance (ESA):

(a) Total and round down to the nearest dollar the community spouse's expenses for the principal place of residence, as defined in rule 5160:1-3-05.13 of the Administrative Code, including any rent or mortgage payment (including principal and interest), current property taxes, insurance, and any required maintenance charge for a condominium or cooperative; then

(b) If the community spouse is responsible for payment towards the cost of gas, electric, coal, wood, oil, water, sewage, or telephone service for the residence, add in the standard utility allowance.

(c) Subtract the ESA standard.

(d) The remainder is the ESA.

(ii) Add the calculated ESA to the minimum monthly maintenance needs allowance (MMMNA) standard to determine the MMMNA. Except in accordance with a hearing decision under rule 5101:6-7-02 of the Administrative Code, the MMMNA must not exceed the MMMNA cap which is updated annually.

(iii) Subtract the community spouse's gross monthly income from the lesser of the MMMNA, calculated in paragraph (G)(4)(a)(ii) of this rule, or the MMMNA cap. If a hearing decision under rule 5101:6-7-02 of the Administrative Code results in a MMMNA that is greater than the MMMNA cap, use the amount established in the hearing decision. The remainder, rounded down to the nearest dollar, is the MIA.

(b) If there is court ordered support that is greater than the MIA calculated above, the court ordered amount is used as the MIA.

(c) If the community spouse's income is still below the MMMNA after all of the institutionalized spouse's income is transferred to the community spouse, the community spouse resource allowance can be increased in accordance with rules 5160:1-6-04 and 5101:6-7-02 of the Administrative Code, to generate additional income for the community spouse.

(5) If the individual has dependent family members, subtract either the family allowance (FA) or the family maintenance needs allowance (FMNA), as calculated in rule 5160:1-6-06 of the Administrative Code. The FA does not apply if there is a FMNA.

(a) The FA is calculated as follows. Subtract a FA if the institutionalized individual has family members residing with his or her spouse in the community.

(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 allowance amount for that family member.

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

(b) The FMNA is calculated as follows. Subtract a FMNA if the institutionalized individual has dependent family members who resided with the institutionalized individual immediately before the individual was admitted to a medical institution. The FMNA does not apply if there is a spouse in the community.

(i) Subtract the combined monthly income of the dependent family members from the FMNA standard; then

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

(iii) The remainder is the FMNA.

(6) The following types of health care costs shall be subtracted from the institutionalized individual's patient liability. Any requests for subtraction of these costs must include documentation that clearly shows the type of medical expense, the amount the individual is responsible for paying, and the date the service or item was provided to the individual.

(a) Health insurance premiums (including medicaid and medicare premiums) and coinsurance, insurance deductibles and copayments, that are incurred by:

(i) The institutionalized individual;

(ii) The institutionalized individual's spouse; or

(iii) The institutionalized individual's minor or disabled child.

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

(i) The service must have been medically necessary as determined by the administrative agency.

(ii) Expenses for medical care shall not have been incurred while serving a restricted medicaid coverage period (RMCP) per rule 5160:1-6-06.5 of the Administrative Code. Expenses that were incurred while serving an RMCP shall not count as unpaid past expenses and shall not be subtracted from the patient liability calculation.

(iii) The request for the subtraction of incurred expenses for medical care can only be initiated by either the institutionalized individual or person or entity who has the legal ability to act on the individual's behalf, including the institutionalized individual's authorized representative. A request for a deduction cannot be initiated by a medical services provider or supplier, unless such provider or supplier is also the institutionalized individual's authorized representative.

(7) Subtract the payment to a financial institution in an amount up to fifteen dollars per month, or the amount approved by the administrative agency, to administer a qualified income trust (QIT) account in accordance with rule 5160:1-6-03.2 of the Administrative Code.

(8) The remainder, rounded down to the nearest dollar, is the individual's monthly patient liability, for a full month of HCBS or PACE services.

(9) The individual's patient liability will be prorated if the individual is enrolled in an HCBS waiver or PACE program for less than a full month. Prorated patient liability is calculated as follows:

(a) Determine the per diem patient liability amount 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.

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

(c) Multiply the actual number of days of institutionalization by the per diem patient liability amount and round this number down to the nearest dollar. This is the individual's prorated patient liability.

(H) The individual will receive written notification of the amount of patient liability for which he or she is responsible. Such notice will explain how the individual can request a hearing if he or she disagrees with the patient liability amount.

(I) If applicable, the individual will receive written notification of the MIA, FA, or FMNA that were calculated in accordance with this rule. Such notice will explain how the individual can request a hearing if he or she disagrees with those amounts.

Replaces: 5160:1-3-04.3, 5160:1-3-04.4

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