Ohio Administrative Code

Rule 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).

Effective: June 1, 2025

(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 who is receiving HCBS waiver or PACE services.

(B) The administrative agency will reduce its payment to the HCBS waiver or PACE providers 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) Providers are to collect the full patient liability amount or up to the cost of care, whichever is less.

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

(F) Patient liability can be established for retroactive eligibility as described in paragraph (L) of rule 5160:1-2-01 of the Administrative Code and will follow the same process as described in paragraph (K) of this rule.

(G) Once eligibility has been established, patient liability cannot be increased for past months.

(H) A patient liability calculated for a child younger than age nineteen shall not increase during the child's continuous eligibility period as described in rule 5160:1-2-14 of the Administrative Code.

Any decrease in a child's patient liability results in a new maximum amount, which will not increase for the remainder of the child's continuous eligibility period.

(I) 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.

(J) 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.

(K) 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) Payments to victims of Nazi persecution.

(b) Austrian social insurance payments based, in whole or in part, on wage credits received under the provisions of the Austrian General Social Insurance Act, paragraphs 500 through 506 (as in effect October 1, 2024). These payments need to be documented and identifiable separate from countable insurance.

(c) Payments from the Dutch government under the Netherlands' Benefit Act for victims of persecution from 1940-1945 (Dutch acronym, WUV) (Pub. L. No. 103-286).

(d) Restitution payments under the Civil Liberties Act of 1988, to U.S. citizens of Japanese ancestry

and permanent resident Japanese non-citizens who were interned during World War II, or their survivors, in accordance with 50 U.S.C. 4215 (as in effect October 1, 2024).

(e) Restitution payments under the Aleutian and Pribilof Island Restitution Act, in accordance with 50 U.S.C. 4236 (as in effect October 1, 2024).

(f) Agent Orange settlement fund payments received on or after January 1, 1989, as a result of the Agent Orange Compensation Exclusion Act (Pub. L. No. 101-201).

(g) 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 (Pub. L. No. 105-78).

(h) Radiation exposure compensation trust fund payments, in accordance with the Radiation Exposure Compensation Act of 1990 (Pub. L. No. 101-426).

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

(i) Certain Vietnam veterans' natural children, regardless of age or marital status, for any disability resulting from spina bifida suffered by such children; and

(ii) Certain Korea service veterans' natural children, regardless of age or marital status, for any disability resulting from spina bifida suffered by such children; and

(iii) The natural children, regardless of age or marital status, with certain birth defects born to a woman who served in Vietnam.

(j) Veterans administration pensions, including payments for aid and attendance, up to the amount of ninety dollars per month, paid to veterans or their surviving spouse, if any, who are residing in a nursing facility or are 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.

(k) Payments made to Native Americans as listed in section IV of 20 C.F.R. 416 Subpart K Appendix (as in effect October 1, 2024).

(l) SSI benefits received under authority of sections 1611(e)(1)(E) and (G) of the Social Security Act (as in effect October 1, 2024) 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 individual's actual stay exceeds the expected stay of ninety days or less.

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

(n) Payments from a state fund for victims of crime.

(o) 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).

(p) Payments from the Ricky Ray Hemophilia Fund Act of 1998 (Pub. L. No. 105-369) or payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corporation, 96-C-5024 (N.D. III).

(q) Payments made to individuals under the Energy Employees Occupational Illness Compensation Program Act of 2000 (Pub. L. No. 106-398).

(r) Assistance (other than wages or salaries) under the Older Americans Act of 1965 under 92 Stat. 1515, 42 U.S.C. 3020a Pub. L. No. 89-73).

(s) Student financial assistance received under the Higher Education Act (HEA) of 1965 (as in effect October 1, 2024) or bureau of Indian affairs is excluded from income, regardless of use:

(i) Pell grants;

(ii) Student services incentives;

(iii) Academic achievement incentive scholarships;

(iv) Federal supplemental education opportunity grants;

(v) Federal educational loans (Stafford loans, William D. Ford federal direct and direct PLUS loans, etc.);

(vi) Upward bound;

(vii) Gear up (gaining early awareness and readiness for undergraduate programs);

(viii) State educational assistance programs funded by the leveraging educational assistance programs; and

(ix) Work-study programs.

(t) Matching funds that are deposited into individual development accounts (IDAs), either demonstration project or TANF-funded, in accordance with 42 U.S.C. 604 (as in effect October 1, 2024).

(u) Accounts under the Stephen Beck, Jr., Achieving a Better Life Experience (ABLE) Act of 2014 (Pub. L. No. 113-295). The following are not considered income to the account holder:

(i) Contributions to an ABLE account by another individual or third party.

(ii) Interest earned on an ABLE account.

(iii) Distributions from an ABLE account.

(v) Federal and state foster care payments received under title IV-B or title IV-E for a child currently living in the household.

(w) Federal or state adoption assistance payments received under title IV-B or title IV-E.

(x) Payments received under the kinship guardianship assistance program (KGAP), state KGAP, or kinship guardianship assistance program connections to twenty-one (KGAP C21).

(y) Child care assistance under the Child Care and Development Block Grant Act of 1990 (Pub. L. No. 113-186).

(z) 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, 2024).

(aa) Payments made for supporting services or reimbursement of out-of-pocket expenses to volunteers participating in corporation for national and community service (CNCS, formerly ACTION) programs in accordance with 42 U.S.C. 1382a (as in effect October 1, 2024):

(i) AmeriCorps VISTA program;

(ii) Special and demonstration volunteer program;

(iii) Retired senior volunteer program (RSVP);

(iv) Foster grandparents program; and

(v) Senior companion program.

(bb) Assistance or services received through federal food and nutrition programs:

(i) Supplemental nutrition assistance program (SNAP);

(ii) The value of foods donated by the U.S. department of agriculture commodity supplemental food

program;

(iii) The value of supplemental food assistance received under the Child Nutrition Act of 1966 (Pub. L. No. 89-642) and the special food service program for children under the National School Lunch Act (Pub. L. No. 90-302);

(iv) The special supplemental nutrition program for women, infants, and children (WIC); and

(v) Nutrition program benefits provided for the elderly under Title VII of the Older Americans Act of 1965 (Pub. L. No. 89-73).

(cc) Assistance received under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Pub. L. No. 100-707) and assistance provided under any federal statute because of a presidentially-declared disaster.

(dd) Assistance, with respect to the dwelling unit occupied by such individual (or such individual and spouse), under the United States Housing Act of 1937 (Pub. L. No. 75-412), the National Housing Act (Pub. L. No. 73-479), section 101 of the Housing and Urban Development Act of 1965 (Pub. L. No. 89-117), title V of the Housing Act of 1949 (Pub. L. No. 81-171), or section 202(h) of the Housing Act of 1959 (Pub. L. No. 86-372).

(ee) Home energy assistance provided on the basis of need, in accordance with 20 C.F.R. 416.1157 (as in effect October 1, 2024).

(ff) Relocation assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 (Pub. L. No. 91-646) provided to individuals displaced by or through any federal, federally-assisted, state, state-assisted, local, or locally-assisted government project in the acquisition of real property.

(gg) 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 (as in effect October 1, 2024).

(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. When the individual has earned income, subtract up to an additional sixty-five dollars from the earned income.

(b) For individuals receiving services under the assisted living waiver or in an assisted living facility receiving services under the mycare waiver, the PNA is the ALMNA. When 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. Individuals receiving PACE services and residing in an assisted living facility are considered to be residing in the community.

(4) When 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) When 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; then

(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 (K)(4)(a)(ii) of this rule, or the MMMNA cap. When 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) When there is court ordered support that is greater than the MIA calculated above, the court ordered amount is used as the MIA.

(c) When the community spouse's income is still below the MMMNA after all of the institutionalized spouse's income is allocated 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) When the individual has dependent family members, subtract either the family allowance (FA) or the family maintenance needs allowance (FMNA). The FA does not apply when there is an FMNA.

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

(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) Subtract an FMNA when 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 when there is a spouse in the community. The FMNA is calculated as follows:

(i) The FMNA standard is the Ohio works first (OWF) payment standard for the same number of applicable dependent family members.

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

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

(iv) 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 medical expenses, and any request to subtract such expenses from the patient liability, must meet the following criteria:

(i) The service was medically necessary as determined by the administrative agency.

(ii) Expenses for medical care were not 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) Unpaid patient liability shall not count as unpaid past medical expenses and shall not be subtracted from the patient liability calculation.

(iv) 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.

(v) Unpaid medical expenses that were incurred in the past may be subtracted from the patient liability as long as the services meet the criteria described in paragraph (K)(6)(b) of this rule.

(7) Subtract the payment 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 when the individual is enrolled in an HCBS waiver or PACE program for less than a full month. Prorated patient liability amounts are 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.

(L) 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.

(M) When 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.