Ohio Department of Job and Family Services

Administrative Appeal Decision

APPELLANT:

CASE NO.

APPEAL NO(S). 1148633

DOCKET NO. 2004-AA-0014

By letter received January 6, 2004, the appellant, through his authorized representative (AR), has requested an administrative appeal of a state hearing decision rendered December 22, 2003. The issue raised on administrative appeal is whether the Hamilton County Department of Job and Family Services correctly calculated the appellant's FS allotment to be $10.00 a month, rather than some higher figure. More specifically, the appellant asserts that the agency failed to include the correct excess medical expense deduction in the FS budget calculation. The state hearing decision overruled the appeal. This administrative appeal decision affirms the state hearing decision.

SUMMARY OF CASE

The state hearing decision indicates that the assistance group (AG) consists of only the appellant, who has been a recipient of the Individual Options (IO) Waiver through the medicaid program, and has been residing in an independent living situation for the mentally retarded/developmentally disabled (MR/DD). The appellant had a zero patient liability for the IO Waiver cost of care.

The appellant was also receiving $781.70 a month in social security benefits, and $98.00 a month in earned income. The appellant's average monthly cost-to-live check from the Hamilton County Board of MR/DD was $40.28. The agency determined the appellant's total gross monthly income to be $919.00.

In determining the appellant's FS eligibility, the agency first subtracted the $134.00 standard disregard, $19.00 earned income deduction (20% of $98.00 monthly earnings) and $23.00 excess medical expense deduction, from appellant's gross monthly income, which yielded an adjusted income of $743.00. The agency granted a $23.00 excess

medical expense in the FS budget, because the appellant was personally responsible for some of the medical expenses he incurred. The agency then subtracted ½ of the adjusted income, or $371.00, from the appellant's utility and shelter care expense total of $483.00 ($153.00 utility allowance + $330.00 in shelter costs), to arrive at an excess shelter/utility cost deduction of $112.00 ($483 - $371 = $112). The appellant's excess shelter/utility costs of $112.00, were then subtracted from the appellant's adjusted income of $743.00, which resulted in net adjusted income of $631.00. Finally, the appellant's countable income of $189.00 (30% of $631) was compared to the maximum FS allotment amount of $141.00 for a one-person household ($141 - $189 = $0.00). Even though the appellant's income exceeded the maximum allotment amount, pursuant to the FS Tables in OAC Rule 5101:4-5-01, the appellant was still entitled to a minimum FS allotment of $10.00 a month. Consequently, on 09/12/03 the agency sent appellant a notice approving FS benefits in the amount of $10.00 a month, effective 09/01/03. The appellant disagreed with the agency's calculation of his FS allotment, so he requested a state hearing, which was held on 12/17/03.

At the state hearing, the agency related the facts set forth in the preceding paragraphs. Appellant and his AR argued at the hearing that the agency failed to grant the appellant an adequate deduction for his excess medical expenses. The AR asserted that as an IO Waiver recipient, the medical services the appellant received, were paid for by the federal medicaid program and by state and county MR/DD Boards, which, pursuant to the AR's interpretation of the Ohio Revised Code (ORC) and Ohio Administrative Code (OAC), the appellant was required to repay to the state of Ohio. Essentially, the AR was alleging that, even though the IO Waiver program was paying for the appellant's services each month, the appellant was actually incurring a monthly medical debt, payable to the state medicaid program and to ODMR/DD, for any IO Waiver services that he received.

Based on the AR's interpretation of state statutes and rules, the AR believed that the IO Waiver expenditures that were used to pay for the appellant's services, should be treated as a deductible excess medical expense in the FS budget, despite the fact that the appellant was not actually paying for these services. Apart from the IO Waiver expense, only the $23.00 excess medical expense, for which the appellant was granted

a deduction, was mentioned at the hearing.

HEARING DECISION

The state hearing officer found that under the IO Waiver program, the appellant's service providers were reimbursed by medicaid, as well as by state and county MR/DD Boards. The hearing officer further found that although the appellant was obligated to repay the state for what was advanced by both medicaid and the MR/DD boards, the FS Rules did not permit the appellant to treat the amount he owed as a deductible excess medical expense, as only "nonreimbursable" medical expenses were allowed to be treated as such. The hearing officer concluded that the appellant's medical providers had in fact been reimbursed, and that the agency had correctly calculated appellant's new FS allotment amount to be $10.00 a month. Consequently, the appellant's appeal was overruled.

REQUEST FOR ADMINISTRATIVE APPEAL

The appellant's AR asserts in the administrative appeal request that the state hearing officer relied solely upon OAC Rule 5101:4-4-23(C) in making his/her decision, which states that unreimbursed medical costs incurred by a disabled individual can be deducted from countable income in the FS budget. The AR believes that the hearing officer should instead have relied upon the following: ORC Sections 5111.11, 5121.04(A) and (B)(1) and 5126.045; and, OAC Rules 5101:1-39-07.1 and 5101:1-39-95(G)(2), which supposedly mandate that the IO Waiver participant be liable to the state medicaid program and state and county MR/DD Boards, for the cost of any medical services received under the IO Waiver program.

The AR also argues that the ODMR/DD statutory agent who testified at the hearing, indicated that the county MR/DDs review the income and assets of each HCBS Waiver participant on a monthly basis, to determine the extent to which the participant is able to make reimbursement to medicaid and state and county MR/DD Boards, for current and past waiver services paid. Should it be determined that an individual has excess income or resources, a bill is generated and issued.

ANALYSIS

ORC §5111.11 and OAC Rule 5101:1-38-10 both state that when an individual age 55 or older receives medicaid-covered services, the cost of these services may be recovered out of the recipient's estate, after the death of both the recipient and his/her spouse, but only if the recipient has no surviving blind or permanently disabled children, or children under age 21. However, the state may waive recovery if they determine that it would cause undue hardship. Although this provision does allow the state to pursue recovery of medicaid costs from the recipient's estate, it is only triggered if the estate has sufficient available resources and assets. Moreover, recovery is only permitted after the death of the IO Waiver recipient and his or her spouse, and after the recipient's children reach adulthood.

ORC §5121.04(A) states that ODMR/DD shall investigate the financial condition of residents whose care or treatment is being paid for in a private facility or home under the control of ODMR/DD, in order to determine the ability of any resident to pay for their own support, as well as for their own clothing. The financial condition of the resident's spouse, and, if the resident is a minor, the resident's parents, shall also be investigated. (B)(1) provides that a resident without dependents shall be liable for the full applicable cost. It is unclear here whether this Rule is even applicable, as there was no finding that the place where the appellant was residing was "under the control of ODMR/DD."

ORC §5126.045 requires county MR/DD boards to establish fees for services rendered to eligible persons, if such fees are required by federal regulation and state rules.

OAC Rule 5101:1-39-07.1(A) states that some of the services provided by ODMR/DD are not covered by medicaid and exceed the individual's available personal income, so in those cases ODMR/DD must document the non-medicaid-covered expenses, in the event the individual later receives a lump-sum payment or available resources are identified, from which ODMR/DD can seek reimbursement. However, Paragraph (D) of the Rule affords the responsible party, which in this case is the appellant, the option of either reimbursing ODJFS and ODMR/DD for non-medicaid-covered expenses, or terminating medicaid and paying privately for medical expenses. Since the Rule permits the recipient the option of either reimbursing the state for non-medicaid-covered

expenses, or terminating medicaid and paying privately for medical expenses, it is clear that there is no obligation to reimburse the state for medical expenses.

OAC Rule 5101:1-39-95(G)(2) states how the patient liability for an individual without a community spouse (CS) is calculated. However, in this case, the hearing decision clearly states that there is no patient liability, so this Rule is inapplicable.

The issue to be addressed is whether the cost of medical services that have been provided to the IO Waiver recipient, who in this case resides in an independent living facility, are allowable as an excess medical expense deduction in the FS budget.

OAC Rule 5101:4-4-23 states: "A deduction is considered in the month the expense is billed or otherwise becomes due." Deductions that are allowed include: "that portion of medical expenses which is nonreimbursable ... incurred by any AG member who is elderly or disabled..." It appears that the appellant is "disabled" for purposes of this determination, and that the costs in question are "medical expenses." Three questions that are subject to dispute are: whether the appellant's medical expenses are "nonreimbursable"; whether the medical expenses have actually been "incurred" by the appellant; and, whether the appellant is actually required to repay the state for the medical expenses.

Issue 1: Whether the appellant's medical expenses are "nonreimbursable"

The AR appears to be asserting that, pursuant to ORC §5121.04, there is a continuing responsibility for all costs of care relating to individuals living in institutions under the control of ODMR/DD. It is unclear whether this provision applies, as there was no finding as to whether the appellant's residence was under the control of ODMR/DD. However, evidence was submitted at the state hearing that indicates a running record is kept of the cost of medical care provided to the individual. OAC Rule 5101:3-1-13.1 states: "the department's payment constitutes payment-in-full for any covered or authorized service. The provider may not bill the consumer for any difference between that payment and the provider's charge." Although payment may be made by the consumer for the responsible eligibility criteria, namely the patient liability, there was no patient liability in this case and it is not at issue in this appeal.

Although the AR asserted at the state hearing that pursuant to the applicable medicaid regulations, the medicaid recipient remains liable for the cost of any medical services, since the costs were reimbursed through the medicaid program, they cannot be considered "nonreimbursable costs" to the recipient. Therefore, the appellant does not meet the criteria set forth under OAC Rule 5101:4-4-23, and cannot take an excess medical expense deduction in the FS budget, beyond the amount he was already granted.

Issue 2: Whether the appellant has actually "incurred" any medical expenses

Assuming for argument's sake that the medical costs would be an allowable deduction, OAC Rule 5101:4-4-23 permits the deduction only in the month the "expense is billed or otherwise becomes due." Since the individual has no continuing responsibility to the provider of medical services, no medical costs have actually been "incurred" by the individual, other than those for which he was already granted a deduction.

Even if the medical costs paid through the IO Waiver were deemed to be "nonreimbursable," in order for there to be any actual liability to the appellant, there would have to be some triggering event, such as the state's determination that there were available resources or income. The resources or income can come from either a lump-sum payment received by the appellant during his life, or the estate of the appellant after his death. The state may use the appellant's lump sum payments to reimburse itself for the cost of non-medicaid-covered services, and estate funds to reimburse itself for the cost of medicaid-covered services. With respect to estate funds, OAC Rule 5101:1-38-10 provides that the state may pursue recovery of **medicaid-covered** expenses from the medicaid recipient's estate, but only after the death of the recipient and the recipient's spouse, and only if the estate has sufficient available assets for it to be worthwhile to pursue recovery.

In the remote event that the state determines that the appellant has available income and/or resources, the state would then have to generate and issue a bill to the appellant. Without both the triggering event and the issuance of a bill, the appellant really cannot be viewed as having "incurred" any medical debt.

Since it does not appear in this case that the appellant has ever been billed for any

medical expenses, beyond the amount for which he was given a deduction, and since some triggering event must occur before the state can even consider billing the appellant for any medical expenses, the appellant cannot be deemed to have "incurred" any other medical expenses, and therefore cannot be granted a deduction for any such expenses in the FS budget.

Issue 3: Whether the appellant is actually obligated to repay the state for the medical expenses

The state may use OAC Rule 5101:1-39-07.1 to pursue recovery, which provides for the occasion when an individual receives a lump-sum, or other resources are identified as available. The Rule provides that ODMR/DD and ODMH may seek reimbursement for the appropriately incurred expenses **not covered by medicaid**. The Rule also provides that, if additional resources remain, the individual, or authorized representative, may dispose of the resources to reestablish medicaid eligibility. Paragraph (D) states: "The CDJFS shall notify the responsible party of the options available to appropriately dispose of excess resources. **One option is reimbursement to ODJFS for medicaid expenses.** However, the options of reimbursing ODJFS, ODMR/DD, or ODMH **or terminating medicaid and paying privately for the medical expenses** remain with the responsible party." (Emphasis added.) Thus, since the appellant has two options under OAC Rule 5101:1-39-07.1, it cannot be said that this particular regulation creates an obligation to repay the state for the cost of any non-medicaid-covered services, or that the regulation establishes a due and payable "bill" of any sort. Similar language appears in OAC Rule 5101:1-39-27.5, which discusses the receipt of "lump-sum payments" for medicaid-eligible individuals.

Conclusion

The medical costs at issue in this case cannot be considered as non-reimbursed, since medicaid did in fact reimburse the providers. Even if the medical costs were considered to be nonreimbursable, no triggering event, such as the location of available assets or income, has occurred, and no bill (other than the one for which the appellant was granted

a deduction) has been issued to the appellant, so the appellant has not actually "incurred" any debt to the state. And, even if a bill were issued for the cost of medical services, the appellant would have the option of terminating medicaid, and paying privately for services, which means that the appellant would have no obligation to repay the state under OAC Rules 5101:1-39-07.1 and 5101:1-39-27.5. Therefore, the medical costs at issue in this case cannot be treated as an excess medical expense deduction in the FS budget.

Based on the appellant's income and the income disregards and deductions to which he was entitled, the hearing officer was correct in concluding that the agency's proposal to approve an FS allotment of $10.00, was proper.

DECISION

The state hearing decision with respect to Appeal Number 1148633 (FS) is AFFIRMED.

Ramesh Thambuswamy, Attorney-at-Law
Administrative Hearing Examiner

Marcia K. Slotnick, Attorney-at-Law
Chief Administrative Hearing Examiner
Office of Legal Services on behalf of
Thomas J. Hayes, Director

DATE OF ISSUANCE January 21, 2004

This Administrative Appeal Decision is the final administrative decision on your case from the Ohio Department of Job and Family Services. If you disagree with this decision, you may have the right to appeal to common pleas court pursuant to Section 5101.35 of the Ohio Revised Code. Your appeal must be filed within thirty days of the date this decision was issued to you. If you have questions about appealing to a court, contact your attorney, local legal aid society, or bar association. If you want information about free legal services, you can call the Ohio State Legal Services Association, toll free, at 1-800-589-5888.

cc: Director, Hamilton County Department of Job and Family Services
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