OHIO DEPT. OF JOB AND FAMILY SERVICES
BUREAU OF STATE HEARINGS
P.O. BOX 182825
COLUMBUS, OHIO 43218-2825

Ohio Department of Job and Family Services
Bureau of State Hearings

State Hearing Decision

Appeal	Program	Disposition	Compliance
3814186	MED-E	OVR	Not Required

Request Date: 11/15/2023
Hearing Date: 01/03/2024
Mail Date: 02/09/2024

Hearing Officer: Mollie Reed

English

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Issue

Appeal Number: 3814186, Medicaid Eligibility Issues, Approval - LTCF

The Appellant submitted a detailed statement of what she owed the assisted living facility in August 2023. Was the County Department of Job and Family Services (CDJFS) correct when it declined to consider room and board fees as an Unpaid Past Medical Bill (UPMB) to retroactively reduce the Appellant's Patient Liability (PL)?

After careful consideration of the information presented during this state hearing, I found the CDJFS's actions were correct.

Procedural Matters

A State Hearing was requested on November 15, 2023 (see Exhibit 1). A second hearing request was submitted on December 15, 2023 (see Exhibit 2). The Authorized Representative (AR) submitted additional information on January 3, 2024 (see Exhibits 3 and 4). The hearing was scheduled for and heard virtually on January 3, 2024. The Appellant was represented by her attorney who was her Authorized Representative (AR). The CDJFS was represented by Gayle Terrell. All parties were sworn in. During the hearing Ms. Terrell emailed the Hearing Officer and the AR a copy of the appeal summary (see Exhibit A). The AR was given 24 hours to respond/rebut the appeal summary, but nothing was forthcoming. The record was closed. Due to delayed scheduling, the decision could not be issued within 30 days of the request date.

Findings of Fact

1. The female Appellant was 94 years as of August 31, 2023. She passed away September 7, 2023.
2. The Appellant had been receiving the MyCare Ohio Assisted Living Waiver since at least January 2022, and residing in an Assisted Living Facility (facility) since 2018 [Exhibit 4, especially see pg. 1].
3. As of May 1, 2022, the Appellant did not owe any money to the facility. She had a credit of $2595.58 [Exhibit 4, pg. 8].
4. On February 7, 2023, the AR requested a State Hearing regarding an Unpaid Past Medical Bill (UPMB) in the amount of $6077.43. The bill was what the Appellant owed the facility. That appeal was withdrawn with compliance. The

CDJFS was ordered to request a breakdown of the billing statement and make a new determination as to whether a December 2021 bill for room and board could be used to reduce the PL. The Hearing decision was issued to all parties on March 1, 2023 [See appeal # 3734321].

5. On March 21, 2023, the AR requested another hearing regarding an Unpaid Past Medical Bill (UPMB) for monies owed to the facility. The AR withdrew that appeal without compliance and a withdrawal notice was issued to all parties on April 25, 2023 [See appeal # 3743471].
6. On May 10, 2023, the CDJFS mailed the Appellant a notice of continuing approval for the assisted living waiver, effective May 1, 2022, with a PL of $241 per month. On September 19, 2023, the AR appealed but the Bureau of State Hearings denied his request as it was untimely [See # 3793234].
7. On August 24, 2023, the AR submitted a detailed billing statement to the CDJFS to show the Appellant owned $4949.13 as of the statement date of June 9, 2023. The Appellant wanted this used to retroactively reduce the PL [Exhibit 3; Exhibit 4].
8. The CDJFS determined the balance of $4949.13 could not be used to retroactively reduce the PL because the money owed was for room and board.
9. On October 5, 2023, the CDJFS mailed the Appellant a notice of reduction in her patient liability (PL). The PL was reducing from $448 to $89, effective September 1, 2023. The notice provided hearing rights. Per the CDJFS, this notice was issued in error as the Appellant had passed away on September 7, 2023 and her eligibility terminated with her death.
10. On November 15, 2023, the AR requested a hearing to dispute the CDJFS's denial of using the $4949.13 to retroactively reduce the PL [Exhibits 1; 4].
11. The AR submitted a brief into the record. Some of his arguments were: pursuant to OAC § 5160-1-01(B), care expenses are medically necessary for someone not covered by EPSDT when the care includes: procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability and without which the person can be expected to suffer prolonged, increased or new morbidity; impairment of function; dysfunction of a body organ or part; or significant pain and discomfort. The

brief also referred to 26 U.S.C § 213; 26 U.S.C § 213(d)(1); and 26 U.S.C § 213(d)(2) to support his argument that facility room and board fees could be used as an UPMB. Per the brief, "26 U.S.C § 213(d)(1) states the term medical care means the amount paid for diagnosis, cure, mitigation, treatment or prevention of disease or for the purpose of affecting any structure or function of the body, including care expenses for qualified long term care services under 26 U.S.C. § 7702(B). He also wrote, 26 U.S.C § 213(d)(2) states the amount paid for lodging away from home for the primary purpose and essential to medical care listed in 26 U.S.C. §213(d)(1) is a medical expense when it is part of the care for someone chronically ill. And 26 U.S.C. § 7702(B)(c)(2) defines "Chronically Ill Individual" as someone who is unable to perform, without substantial assistance from another individual at least two activities of daily living for a period of at least 90 days or due to loss of functional capacity or requires substantial supervision to protect such individual from threat to health and safety due to a cognitive impairment. When these conditions are met, all expenses, including lodging and food, are deemed to be a medical expense and allowed for inclusion for deduction from taxable income. The government, including the County, has long held costs associated with a chronically ill individual who is institutionalized for purposes of receiving medical care, then all their expenses, including the cost of lodging and food, are necessary to the individual and must be considered a medical expense. This standard has become the norm in all government programs. Within the VA programs, once intermediate level care need has been established and the individual is a resident at an assisted living or nursing home, all expenses associated with care are deemed necessary care expenses and used to calculate program eligibility [Exhibit 4].

12. The AR also argued in his brief that under the Ohio Assisted Living program, all the care expenses of the resident are considered medical expenses with the exception of $864.00 per month. Further, when considering the necessary care expenses, OAC 5160-1-01 does not segregate housing and food costs from care expenses. In the instant case, the County has the duty to prove the expenses were unnecessary. With the evidence [name withheld] met the intermediate level of care, that she was residing in an assisted living community receiving assistance with multiple ADL care needs and then

ultimately approved for Medicaid assisted living enrollment since August 1, 2022 to the present, the County has clearly failed [sic] carry their burden of proof. The care expenses of [name withheld] have remained constant since her admission is 2020. To carve out a 4-month period in the middle of this period and deem eliminate any portion of the care expenses as unnecessary is error and must be reversed [Exhibit 4].

13. Additionally, the AR argued in his brief the County relies upon OAC § 5160-33-7(G) to support the portion of the Assisted Living Expenses that will be covered as a medical expense. Paragraph (G) states: The assisted living service payment is for the assisted living services as defined in rule (OAC) 173-39-02.16 of the Administrative Code and does not include payment for room and board as calculated by rule 5160-33-03 of the Administrative Code, which is the responsibility of the individual. OAC 5160-33-03 is the Ohio Administrative Code Section used to calculate eligibility for the Medicaid funded component of the assisted living program. The “room and board” portion of the code is set forth in OAC 5160-33-03(B)(5). This portion of the rule required the Applicant to have the ability to made room and board payment calculated at the current supplemental security income (SSI) federal benefit level minus fifty dollars. Currently, that value is set at $864.00 per month [Exhibit 4].

Conclusion of Policy
Policy

Ohio Administrative Code 173-39-02.16 - ODA provider certification: assisted living service. “Assisted living service" means all of the following:

(A)(1)(a) A service promoting aging in place by supporting the individual's independence, choice, and privacy. (b) A service that includes the following activities: (i) Hands-on assistance, supervision, and/or cuing of ADLs, IADLs, and other supportive activities. (ii) Nursing activities, including the following: (a) The initial and subsequent health assessments under rule 3701-16-08 of the Administrative Code. (b) Monitoring the individual according to the standards of practice for the individual's condition. (c) Medication management according to rule 3701-16-09 of the Administrative Code. (d) The part-time intermittent skilled nursing care described in rule 3701-16-09.1 of the Administrative Code when not available to the individual

through a third-party payer. (iii) Coordinating three meals per day and snacks according to rule 3701-16-10 of the Administrative Code with access to food according to rule 5160-44-01 of the Administrative Code. (iv) Coordinating the social, recreational, and leisure activities under rule 3701-16-11 of the Administrative Code to promote community participation and integration, including non-medical transportation to services and resources in the community.

(c) **A service that does not include the following: (i) Housing. (ii) Meals**. (iii) Twenty-four-hour skilled nursing care. (iv) One-on-one supervision of an individual. (2) "Medication management" includes knowing what medications an individual is self-managing, assistance with self-administration of medication, ordering medication, medication reminders, and medication administration. (3) "Memory care" means a service that a provider provides in compliance with paragraph (D) of this rule to an individual with a documented diagnosis of any form of dementia. (4) "Resident call system" has the same meaning as in rule 3701-16-01 of the Administrative Code. (5) "Staff member" and "staff" have the same meanings as in rule 3701-16-01 of the Administrative Code. Ohio Admin. Code §173-39-02.16(A)(1)(a)(b)(c)(i)(ii).

“Level of care determination" means an assessment and evaluation by ODJFS or its designee of an individual's physical, mental, social, and emotional status, using the processes described in [rules 5101:3-3-15, 5101:3-3-15.3, and 5101:3-3-15.5 of] the Administrative Code, to compare the criteria for all of the possible levels of care as described in rules 5101:3-3-06 to 5101:3-3-08 of the Administrative Code, and make a decision about whether an individual meets the criteria for a level of care. Ohio Administrative Code §5160:3-05 (B)(17)(2012).

Assistance, as defined in rule 5101:3-3-05 of the Administrative Code, with the completion of a minimum of two activities of daily living (ADL), as defined in rule 5101:3-3-05 of the Administrative Code and as described in paragraph (C) of this rule. Ohio Admin. Code §5160-3-08(B)(4)(a)(2012).

"Activity of daily living (ADL)" means a personal or self-care task that enables an individual to meet basic life needs. For purposes of this rule, the term "ADL" includes the following defined activities: (a) "Bathing" means the ability of an individual to cleanse one's body by showering, tub, or sponge bath, or any other generally

accepted method. (b) "Dressing" means the ability of an individual to complete the activities necessary to dress oneself and includes the following two components: (i) Putting on and taking off an item of clothing or prosthesis; and (ii) Fastening and unfastening an item of clothing or prosthesis. (c) "Eating" means the ability of an individual to feed oneself. Eating includes the processes of getting food into one's mouth, chewing, and swallowing, and/or the ability to use and self-manage a feeding tube. (d) "Grooming" means the ability of an individual to care for one's appearance and includes the following three components: (i) Oral hygiene; (ii) Hair care; and (iii) Nail care. (e) "Mobility" means the ability of an individual to use fine and gross motor skills to reposition or move oneself from place to place and includes the following three components: (i) "Bed mobility" means the ability of an individual to move to or from a lying position, turn from side to side, or otherwise position the body while in bed or alternative sleep furniture; (ii) "Locomotion" means the ability of an individual to move between locations by ambulation or by other means; and (iii) "Transfer" means the ability of an individual to move between surfaces, including but not limited to, to and from a bed, chair, wheelchair, or standing position. (f) "Toileting" means the ability of an individual to complete the activities necessary to eliminate and dispose of bodily waste and includes the following four components: (i) Using a commode, bedpan, or urinal; (ii) Changing incontinence supplies or feminine hygiene products; (iii) Cleansing self; and (iv) Managing an ostomy or catheter. Ohio Admin. Code §5160-3-05(B)(2)(2012).

“NF-based level of care" means the intermediate and skilled levels of care, as described in rule 51[60]:3-3-08 of the Administrative Code. Ohio Admin. Code (OAC) §5160:3-05 (B)(27)(2012).
(B) The criteria for the intermediate level of care is met when: (1) The individual's needs for long-term services and supports (LTSS), as defined in rule 5101:3-3-05 of the Administrative Code, exceed the criteria for the protective level of care, as described in paragraph (B)(3) of rule 5101:3-3-06 of the Administrative Code. (2) The individual's LTSS needs are less than the criteria for the skilled level of care, as described in paragraph (D)(4) of this rule. (3) The individual's LTSS needs do not meet the criteria for the ICF-MR-based level of care, as defined in rule 5101:3-3-05 of the Administrative Code. (4) The individual has a need for a minimum of one of the following: (a) Assistance, as defined in rule 5101:3-3-05 [note: 5101:3-3-05 was replaced with 5160:3-08] of the Administrative Code, with the completion of a

minimum of two activities of daily living (ADL), as defined in rule 5101:3-3-05 of the Administrative Code and as described in paragraph (C) of this rule; (b) Assistance with the completion of a minimum of one ADL as described in paragraph (C) of this rule, and assistance with medication administration, as defined in rule 5101:3-3-05 of the Administrative Code; (c) A minimum of one skilled nursing service or skilled rehabilitation service, as defined in rule 5101:3-3-05 of the Administrative Code; or (d) Twenty-four hour support, as defined in rule 5101:3-3-05 of the Administrative Code, in order to prevent harm due to a cognitive impairment, as diagnosed by a physician or other licensed health professional acting within his or her applicable scope of practice, as defined by law. (C) For the purposes of meeting the criteria described in paragraph (B)(4) of this rule, an individual has a need in an ADL when: (1) The individual requires assistance with mobility in at least one of the following three components: (a) Bed mobility; (b) Locomotion; or (c) Transfer. (2) The individual requires assistance with bathing. (3) The individual requires assistance with grooming in all of the following three components: (a) Oral hygiene; (b) Hair care; and (c) Nail care. (4) The individual requires assistance with toileting in at least one of the following four components: (a) Using a commode, bedpan, or urinal; (b) Changing incontinence supplies or feminine hygiene products; (c) Cleansing self; or (d) Managing an ostomy or catheter. (5) The individual requires assistance with dressing in at least one of the following two components: (a) Putting on and taking off an item of clothing or prosthesis; or (b) Fastening and unfastening an item of clothing or prosthesis. (6) The individual requires assistance with eating. Ohio Admin. Code §5160:3-08(B)(2012).

“Assisted living HCBS waiver program" means the medicaid-funded component of the assisted living program created under section 173.54 of the Revised Code and approved by the centers for medicare and medicaid services. Ohio Admin. Code §5160:33-02 (C)(2022).

"Room and board" means a payment made by an individual enrolled in the assisted living waiver directly to the ODA certified assisted living waiver provider. When paying "room" the individual will not be charged for the same furnishings and other shelter expenses the residential care facility provides at no cost to private pay non-waiver residents pursuant to the facility's resident agreement. The term "board" means three meals a day or any other full nutritional regimen. Room and board does not include

charges for ancillary items, services, and/or social activities purchased or paid for by the individual including hygiene and supplies not provided through medicaid and reflected on the individual's person-centered services plan, recreation and activities, and/or other items or services purchased by the individual; however ODA certified assisted living providers may, at their own discretion, provide ancillary items, services and/or social activities as part of the room and board payment. Ohio Admin. Code §5160:33-02 (N)(2022).

To be eligible for the medicaid funded component of the assisted living program, an individual must have an intermediate or skilled level of care in accordance with rule 5160-3-08 of the Administrative Code…And the individual must have the ability to make room and board payments calculated at the current supplemental security income (SSI) federal benefit level minus fifty dollars (Ohio Admin. Code §5160:33-03 (B)(2)(5)).

Ohio Admin. Code §5160:1-6-07 contains policy related to calculating patient liability.

(A) This rule describes how to calculate an institutionalized individual's post-eligibility treatment of income (PETI), commonly referred to as patient liability or share of cost. This rule only applies to an individual residing in a medical institution who does not have a base eligibility category which uses the modified adjusted gross income (MAGI) budgeting methodology in accordance with Chapter 5160:1-4 of the Administrative Code.

(B) The administrative agency will reduce its payment to a medical institution, for services provided to an institutionalized 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 the medical institution.

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

(F) Medical institutions are required to refund to the institutionalized individual any overpayments of patient liability paid by the institutionalized individual, such as when retroactive patient liability adjustments are made.

(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 supplemental security income (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… (c) Payments from the Dutch government under the Netherlands' Benefit Act for victims of persecution… (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…;(e) Restitution payments under the Aleutian and Pribilof Island Restitution Act…

(f) Agent Orange settlement fund payments…(g) Department of defense payments to certain persons captured and interned in North Vietnam…(h) Radiation exposure compensation trust fund payments…(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; (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…(k) Payments made to Native Americans as listed in section IV of 20 C.F.R. 416 Subpart K Appendix…(l) SSI benefits received under authority of sections 1611 (e)(1)(E) and (G) of the Social Security Act (SSA) (as in effect October 1, 2022) for institutionalized individuals during the first three full months of institutionalization…(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 compensation 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…(p) Payments from

the Ricky Ray Hemophilia Fund Act of 1998 […] or payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corporation…(q) Payments made to individuals under the Energy Employees Occupational Illness Compensation Program Act…(r) Assistance (other than wages or salaries) under the Older Americans Act of 1965 (Pub. L. No. 89-73). (s) Student financial assistance received under the Higher Education Act (HEA)…(t) Matching funds that are deposited into individual development accounts (IDAs)…(u) Accounts under the Stephen Beck, Jr., Achieving a Better Life Experience (ABLE) Act of 2014… (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)…(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…(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 […] (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 on October 1, 2022). (ff) Relocation assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970… (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, 2022).

(3) Subtract a personal needs allowance (PNA) of fifty dollars. When the individual has earned income, subtract up to an additional sixty-five dollars from the earned income amount.

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

(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. These unpaid past 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… (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…. (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 institutionalization.

(9) When the institutionalized individual is institutionalized for less than a full month due to date of admission, death, or discharge from the medical institution, the patient liability amount is prorated for that month. Prorated patient liability amounts are calculated as follows. (a) 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. (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 amount, rounding down to the nearest dollar. This is the institutionalized individual's prorated patient liability amount. (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. Ohio Admin. Code §5160:1-6-07(2023).

Medical necessity for individuals not covered by EPSDT is criteria of coverage for procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability and without which the person can be expected to suffer prolonged, increased or new morbidity; impairment of function; dysfunction of a body organ or part; or significant pain and discomfort.

(C) Conditions of medical necessity for a procedure, item, or service are met if all the following apply: (1) It meets generally accepted standards of medical practice; (2) It is clinically appropriate in its type, frequency, extent, duration, and delivery setting; (3) It is appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome; (4) It is the lowest cost alternative that effectively addresses and treats the medical problem; (5) It provides unique, essential, and appropriate information if it is used for diagnostic purposes; and (6) It is not provided primarily for the economic benefit of the provider nor for the sole convenience of the provider or anyone else other than the recipient.

(D) The fact that a physician, dentist or other licensed practitioner renders, prescribes, orders, certifies, recommends, approves, or submits a claim for a procedure, item, or service does not, in and of itself make the procedure, item, or service medically necessary and does not guarantee payment.

(E) The definition and conditions of medical necessity articulated in this rule apply throughout the entire medicaid program. More specific criteria regarding the conditions of medical necessity for particular categories of service may be set forth within the Ohio department of medicaid (ODM) coverage policies or rules. Ohio Admin. Code §5160-1-01(B)(C)(D)(E)(2022).

IRS code 26 U.S.C. §213(d) allows lodging and food to be deductible medical expenses if the allowable expenses exceed 7.5% of the individuals adjusted gross income (also see IRS pub. 502).

Other:

The hearing officer's findings of fact shall be based exclusively on the evidence introduced at the hearing… Direct evidence shall normally be given more weight than hearsay evidence when the two are in conflict. The hearing officer's conclusions of policy and recommendations shall be based solely on rules of the Administrative Code, or local agency policy adopted pursuant to options authorized in state law, except when these regulations and policies are silent and reference to the Revised Code or other statutory source is necessary to resolve the issue. It shall be the responsibility of the agency to show, by a preponderance of the evidence, that its

action or inaction was in accordance with rules of the Administrative Code. Ohio Admin. Code § 5101:6-7-01 (C).

Analysis

Appeal Number: 3814186, Medicaid Eligibility Issues, Approval - LTCF

The AR submitted a detailed statement of the Appellant's past due room and board fees on August 24, 2023. He asserted that the charges were unpaid past medical expenses which were not acted upon by the CDJFS to retroactively reduce the patient liability (PL).

The CDJFS determined it could not use the past due room and board as an UPMB. The Hearing Officer found the CDJFS was correct not to use the past due room and board fees to reduce the PL.

Per policy, room and board for an assisted living individual cannot be considered past unpaid medical expenses (Ohio Admin. Code §5160:1-6-07 (G)(6)(b)(iii)). The rule is clear that facility room and board cannot be used as an UMPB to reduce PL.

The AR's brief held that 26 U.S.C § 213; 26 U.S.C § 213(d)(1) and 26 U.S.C § 213(d)(2) supported room and board fees should be used to reduce the PL. The Hearing Officer found that the U.S.C. code(s) were IRS tax codes describing what could be used as a deduction from taxable income. The Hearing Officer found whether the Appellant could claim facility room and board as a tax deduction was irrelevant and his argument held no merit.

While IRS code 26 U.S.C. §213(d) allows lodging and food to be deductible medical expenses, Ohio Admin. Code §5101:6-7-01 (C)(2) requires state hearing decisions to be based on the Ohio Administrative Code unless the Code is silent. The Code is not silent as to what constitutes covered medical expenses and UPMBs.

The AR's brief argued the care the Appellant received in the facility was medically necessary because she met an Intermediate Level-of-Care (ILOC) (refer again to Exhibit 4). The Ohio Administrative Code is clear that room and board charges are not considered medical expenses for Medicaid recipients residing in a facility and approved for an assisted living waiver, therefore, the argument has no merit (Ohio Admin. Code §173-39-02.16(A)(1)(c)(i)(ii)).

The AR also argued in his brief that Ohio Administrative Code section 5160-33-07(G) provides that the assisted living waiver program does not include payment for room and board, which is the responsibility of the individual (refer again to Exhibit 4). The CDJFS used this rule to support not using the room and board fees as an UPMB. The Hearing Officer found the CDJFS was correct not to use room and board fees as an UPMB.

To be eligible for the medicaid funded component of the assisted living program, an individual must have an intermediate or skilled level of care in accordance with rule 5160-3-08 of the Administrative Code…And the individual must have the ability to make room and board payments calculated at the current supplemental security income (SSI) federal benefit level minus fifty dollars (Ohio Admin. Code §5160:33-03 (B)(2)(5)).

The AR's brief also argued that Ohio Admin. Code §5160:33-03 (B)(5) supported all but $864 a month of what the Appellant owed should be used as an UPMB to reduce the PL retroactively (also refer again to Exhibit 4). The Hearing Officer found Ohio Admin. Code §5160:33-03 (B)(5) explains how the room and board fee are calculated and does not support that all but $864 a month should be used as an UPMB.

Ohio Administrative Code section 5160-33-02 (N) explains "room and board" means a payment made by an individual enrolled in the assisted living waiver directly to the certified assisted living waiver provider. The Appellant was required to pay the facility for her room and board.

The CDJFS representative believed the matter has already been adjudicated in February 2023 when the previous hearing was heard on February 7, 2023. At the time, the AR requested a hearing regarding an UPMB of $6077.43; money the Appellant owed the facility for services provided in January 2022. The appeal was withdrawn with compliance. The CDJFS was to request a breakdown of the billing statement and make a new determination as to whether the December 2021 bill could be used to reduce the PL. The Hearing decision was issued to all parties on March 1, 2023 [See appeal # 3734321].

The AR argued in his brief that care expenses were medically necessary and therefore, facility room and board fees should be used to reduce the PL. The Hearing

Officer found that while care expenses are medically necessary under Ohio Admin. Code §5160-101 (B), room and board are not considered care expenses under the Ohio Administrative Code (Ohio Admin. Code §173-39-02.16(A)(1)(c)(i)(ii)).

Room and board refers to housing and meals, which as stated in Ohio Admin. Code §173-39-02.16(A), is not a covered assisted living expense, so are not medical expenses and cannot be used as UPMBs.

Ohio Administrative Code §173-39-02.16(A) defines what an assisted living service is and specifically explains room and board is not considered a service; therefore, are not considered medically necessary. *A service that does not include the following: (i) Housing. (ii) Meals (emphasis added)*. Ohio Administrative Code §173-39-02.16 (A) clearly states that housing and meals do not meet the definition of an assisted living service.

Ohio Admin. Code 5160:1-6-07(G)(6) addresses the application of UPMB to the PL/SOC. The rule specifically states that UPMBs consist of the cost for medical care recognized under Ohio law. As Ohio Administrative Code disallows room and board as being covered assisted living expenses, they do not constitute UPMBs and cannot be used to reduce any PL/SOC.

Ohio Admin. Code §5160-1-01(B) defines medical necessity: Medical necessity for individuals not covered by EPSDT is criteria of coverage for procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability and without which the person can be expected to suffer prolonged, increased or new morbidity; impairment of function; dysfunction of a body organ or part; or significant pain and discomfort. Because room and board are not medical expenses, medical necessity does not apply.

In conclusion, I found the CDJFS's actions were supported; thus, the appeal should be overruled.

Hearing Officer's Recommendation

Appeal Number: 3814186

Based on the record and policy before me, I recommend that appeal 3814186 be

Overruled.

Final Administrative Decision and Order

Regarding appeal number 3814186, I find the Hearing Officer's decision to be supported by the evidence and regulations. The recommendations above are adopted, and the appeal is Overruled.

John Fitzmaurice

02/09/2024

Notice to Appellant

This is the official decision of your state hearing. It informs you of the decision and order in your case. Papers and materials introduced at the hearing, known as "exhibits," make up the hearing record. The hearing record is maintained by the Ohio Department of Job and Family Services. If you would like a copy of the official record, please call the ODJFS hotline at 1-866-635-3748.

Important Notice: If you disagree with this decision, you, or your authorized representative, may request an administrative appeal about this notice. Contact us using one of the following methods:
Email - bsh@jfs.ohio.gov. In the subject, put "Administrative Appeal Request".
Fax - (614) 728-9574
Mail - ODJFS Bureau of State Hearings, P.O. Box 182825, Columbus, Ohio 43218-2825.

Your administrative appeal request should include a copy of this notice and the reason you think it is wrong. Your written request must be received by the Bureau of State Hearings within 15 calendar days from the mailing date of this notice. (If the 15th day falls on a weekend or holiday, this deadline is extended to the next work day.)

Unless you request an administrative appeal, this notice is a final and binding decision about your state hearing request. Any fair hearing benefits you receive will end. This may also mean the local agency can go ahead with the action it was planning to take. Additionally, you may have to pay back the continuing benefits you received as part of the state hearing process.

You can ask your local Legal Aid program for free help with your case. Contact your local Legal Aid office by phoning 1-866-LAW-OHIO (1-866-529-6446) or by searching the Legal Aid directory at https://www.ohiolegalhelp.org/find-your-legal-aid on the internet.

Appendix

Appellant Exhibits

1. Request-SH (3 pages)
2. HR2 (3 pages)
3. EX 3 Appellant Document (19 pages)
4. EX 4 Appellant Document (5 pages)

Agency Exhibits

A. Exhibit - County- AS (34 pages)

Jurisdictional Exhibits

1. JD (2 pages)

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