

Chair Gross, Vice-Chair Barhorst, Ranking Member Baker, and members of the House Medicaid Committee, I come before this committee as a proponent of HB 130.

In the folders in front of you I have listed my Medicaid Estate Recovery Notice Goals.

The information in the folder is Evidence of a much-needed change to the Medicaid Recovery Notice and the language used in the notice.

It will be important that you review the information in the folder to understand how important that bill HB 130 is.

I would like to take a small amount of time to review some of the highlights of the evidence.

Evidence of a much-needed change to the Medicaid Recovery notice process and language used in the notice.

Rules of engagement.

- 1. Bob is not out to trash Medicaid. Medicaid provides much-needed help to the poor, sick and needy.**
- 2. When Bob Weldon is incorrect in his understanding of this process and language, such individual needs to correct Bob in writing with documentation. I want transparency and accountability.**
- 3. Make a choice to join our team to fix this process and language. If you choose not to let me know and I will go elsewhere.**

Comments

**The current process lacks solid leadership.
Which leads to the lack of accountability.
Which leads to the lack of credibility.**

You cannot change what you do not confront.

Bob Weldon

Concerned Citizen.

740-503-8181

bob@tomjonesins.com

Medicaid Estate Recovery Notice Goals

1. Change the process to make sure the applicant or beneficiary receives a proper notice of estate recovery.
2. Make the language easy to understand.
3. Provide enough language that an applicant can make an educated decision.

Example in writing.

The applicant understands that if you are permanently institutionalized or age 55 or older and not a permanently institutionalized individual and you receive Medicaid Benefits, the Estate Recovery Program may recover payments for the cost of your care paid by Medicaid from your estate. The cost of your care may include the managed care premium for Example (MyCare 2021 rate of \$3562.49 per month) that Medicaid pays to your managed care plan, even if the managed care premium payment is greater than the cost of services you received.

Another example would be (SRS Plan) 2020 rate per month of \$1785.16.

Another example would be (ACA) Health insurance plan from the federal exchange rate of \$1220.38

Realizing that the exact rate may be hard to determine. A state average would be used with each plan that has a managed care premium.

4. A signature of understanding on the new easy to understand disclosure form must be on record within XX days after benefits begin.

5. All parties involved in the Estate Recovery notice process need to have fiduciary responsibility to the applicants or beneficiaries.

6. To make sure that proper notification is completed. If such documentation is not present at the time of estate recovery such a recovery will be null and void.

All the above would help to resolve the issues that I have read in many studies sent to congress. Along with my own experience, along with many other stories that came from other individuals who experienced same types of problems.

Philip A Weldon Deceased

Medicaid Claim Amount: \$3570.32

Client No.: 5918.550

To whom this may concern:

On January the 16, 2020 in the morning my brother Philip A Weldon requested that I be at a meeting with him and our mother in regards to Ohio Medicaid at his home at 12205 Lancaster St Millersport Ohio at 1 pm.

Upon my arrival Hilda Lyatuu from Central Ohio Area Agency on Aging was present. I asked how Phil was eligible for Medicaid. She stated that due to his cancer he could make up to \$27,756 per year and qualified for services thru COAAA. She stated that there were all kind of services that we available such as someone could come to the house to clean, wash dishes and many other items. One item that my brother thought was a good idea was a stair lift to be able to get to the second floor of the home.

I asked Hilda how much all of this would cost. She said it was free. I once again asked are you sure about that. Her words were "Nothing. Not a dime."

She stated that paper work needed to be submitted and it would take from 4 to 6 weeks and he would be notified by mail of the approval. Paper work was completed. (See attached Ohio department of Medicaid Home and Community-Based Services Settings Verification Check list signed by Philip and Hilda Lyatuu.)

Out of being skeptical I made a phone call to Lee Ann Blair, Phil's social worker with Fair Hope Hospice and Palliative Care. I asked her if she knew anything about this SRS program and she stated she didn't. I gave her Hilda Lyatuu's phone number to check it out. She received an email from Hilda's supervisor Katie Waugh. In this email there was a link to the Ohio Medicaid Specialized Recovery Services.

On the front page of the link at the bottom there were two other links. One SRS Frequently Asked Questions. The other SRS Consumer Handbook. (See attachment's).

Note on page 3 of 3 of the Frequently Asked questions. ARE THERE ANY COSTS ASSOCIATED WITH THE SRS PROGRAM? The answer is "No. There is no cost to apply and there are no co-payments or premiums for the SRS program." This confirms to me what I was told by Hilda Lyatuu.

Around February 20th a letter from Fairfield County Job and Family Services dated 2-13-2020 was received stating that a decision had been made that he will get Specialized Recovery Services Program beginning on 2-1-2020 along with an Ohio Medicaid card. (See attached).

After receiving the approval letter, I called into the Fairfield County Job and Family services and asked to change the Medicaid insurance thru CareSource. They informed me that I needed to send in the designation of Authorized Representative form which was done and faxed in on 2-24-2020 at 11:19 Am.

I then made contact with Healthcare.gov to let them know that Phil was now on Medicaid and that coverage need to be cancelled back to 2-1-2020 with Care Source.

Soon after this Philip took a turn for the worse and was taken to The Picking House in Lancaster Ohio where he was until his death 3-4-2020.

On March 31, 2020 my sister Lana Guinan who works with the law firm of Sitterley, Vandervoort & Davis did an inquiry for Medicaid recovery.

A Letter form Todd D Pechar special Counsel 23010 Ohio Attorney General was sent back to Lana showing an amount due for \$3570.32 for two months of Managed Care Premium payments for February and March of 2020.

She forwarded a copy on to me.

My brother had health insurance thru the federal market place with Care Source for \$213.83 per month.

Who in their right mind would sign up for a health plan at a rate of \$1785.16 when you had a plan for \$213.83?

There was never at any time an Ohio Medicaid Estate Recovery disclosure presented to my brother or me.

Since then I have been asking a lot of questions of how this complete failure to disclose came about?

1. When I was told by Hilda Lyatuu a recovery manager from Central Ohio Area Agency on Aging that this would not cost anything. "Not a dime."

2 When the Medicaid website for Specialized Recovery Services states in the SRS Frequently Asked Questions information states on page 3. Are there any costs associated with the SRS Program? No. There is no cost to apply and there are no-copayment or premiums for the SRS program.

3. The Ohio Department of Medicaid Recovery Management Hand book states under the title of "Your Rights." "Be kept informed with material that is accurate and EASY To UNDERSTAND."?

4. Not until after the fact that I had to ask for a copy of the Ohio Medicaid Estate Recovery form ODM 07400 (Rev 01/2018)

Me being the medical POA and durable POA I feel I did my due diligence in trying to make sure what happened didn't happen.

On June the 6th 2020 I called a spoke with Hilda Lyatuu about her visit with my brother Phil, mother Goldie and I. I asked her if she remembered me asking her how much all of the services would cost and she said "yes". Do you remember telling us "nothing Not a dime" she said yes? I then in proceed to tell her that my brother had passed on 3-4-2020 and now we have a bill due for \$3,570.32. She said to me "That's not how I understand it and you will need to talk to my supervisor".

I was transferred to Katie Waugh. I explained what had taken place and I was upset that they had employees out offering services without a notice of Ohio Medicaid Estate Recovery notice. I explained that I asked more than once about the cost. She stated that they COAAA was not a part of Medicaid.

My comment to her was your employee signed an Ohio Department of Medicaid Home and Community-Based services (HCBS) Setting Verification checklist (See attached) as a recovery manager. I said I believe she is some type of agent of Ohio Medicaid program.

She stated that she would check into the issues and have her supervisor contact me.

On June the 4th 2020 in the afternoon I received a phone call from Carrie Oswald from COAAA. She asked me to open my email. I opened the email (See Attached Email dated June 4th) she stated that their office had been talking on how they could head off a problem in the future.

She stated "Beginning today, we have included an Estate Recovery fact sheet in our enrollment documents and initial assessment procedure. This way those who are enrolling receive this information *not only from Job and Family Services* when applying for Medicaid, but also from the SRS program".

She asked me to file a complaint with the Ohio Medicaid Consumer Hotline in regards to the miss information on the website and have my issues resolved. I placed the call to the hotline that day.

I received a call from Teresa LeSaint Technical Assistance and Compliance at the Bureau of Business operational Support with the Ohio Department of Medicaid. I explained what had taken place. She stated the following with a follow up email dated Friday June 12 2020. (See Attached). "When determining Medicaid eligibility for SRS, the county worker determines financial and non-financial eligibility. The recovery managers (with CareSource or CareStar), determine if the individual meets the SRS criteria for the program. The recovery managers are not Medicaid eligibility workers and may not be aware of the Medicaid Estate Recovery policy. It would be the county worker's responsibility to inform Medicaid applicants and recipients of the Estate Recovery policy to individuals who are age 55 or older or institutionalized."

I told her my brother or I didn't receive a call from a county worker. I told her I had placed a call to the county about a week earlier trying to figure out how the referral came about and had not received a call back yet. I told her that I was shocked that there was not a complete disclosure and a sign off of understanding of the Ohio Medicaid Estate Recovery before the SRS paper was sent in.

I received a call from Melanie Culbertson from Fairfield County Jobs and Family Services. I asked her how the referral to CAOAAA came about. She stated that it came from the notice from the Federal Market place where when my brother's health insurance was applied for on 11-06-2020.

I asked when a notice of Estate recovery would be given. She stated that "if there was a conversation it would be given at that time". I asked who spoke with me or my brother Phil. She stated that she did see any record of that. I explained what had happened and she also said she would talk to her manager and have her give me a call.

I received a call back from Krystal Humphrey Social Service Manager from Fairfield County Job & Family Services. She wanted to know what she could do to help me. I asked her if she understood what had happened. She stated "yes". I asked her if she thought that there was a problem and she said "yes".

I asked her how we were going to fix it. She stated her office was limited on what they were able to do and would once again speak to her superior.

So, at this point I feel that I'm going to have to get the media and state representative involved due to the fact I cannot do this by myself.

I feel that the estate only owes to the Ohio Medicaid Estate Recovery the two months of Care Source premium of \$427.66 minus any cost to the estate for having a letter written to Todd D Pechar to dispute the balance due. That was recommended by Todd D Pechar after I explained what had taken place. I would also like to note that he stated to me when I spoke to him about what happened that "You know there is no free lunch".

1. We did not go looking for anything Free!
2. We and He should expect people who are sick and elderly to have complete and full disclosure!
3. Brother Phil was one person in Fairfield County who experienced this. I wonder how many more are out there who have been told that "it will not cost a dime". There are 88 Counties in Ohio and I wonder how many know what they have signed up for?
4. I question if there shouldn't be a complete audit of these types of services that are offered up without a complete signed disclosure?

Ohio Department of Medicaid
Home and Community-Based Services (HCBS) Settings Verification Checklist

Section I: Qualities Required for All Home and Community-Based Settings
Complete this section for each individual, regardless of his or her current living arrangement. Do not complete if the individual is homeless or in transitional housing.

The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community.

1. Does the individual reside in a setting that he or she owns or leases or is owned or leased by a member of the individual's family? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	2. Does the individual reside in a setting that is owned or leased by the same party that furnishes HCBS services in the setting? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	3. Is the individual able to describe how he or she accesses the community, including who assists in facilitating the activity and where he or she goes? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, complete questions 3 through 9 and do not complete Section II.

The setting is selected by the individual from among setting options including most disability specific settings and an option for a private unit in a residential setting.

4. Was the individual given a choice of available options regarding where to live/receive services? Yes No

The setting ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

5. Does the individual have access to telephones or other electronic devices to use for personal communication in private and at any time? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6. Does the individual know how to file a complaint about his or her level of involvement with the greater community? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	7. Does the individual report his/her daily activities are unrestricted and there is no use of interventions like those that might be used in an institutional setting (seclusion, physical or chemical restraints, locked doors)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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The setting optimizes opportunities for the individual to make choices and control his or her own schedules regarding daily activities, physical environment, and with whom to interact.

8. Does the individual have opportunities to make informed choices about when tasks, services and activities are furnished?
 Yes No

The setting facilitates choice regarding services and supports and who provides them.

9. Does the individual make informed choices about who provides services to him or her?
 Yes No

Section II: Additional Conditions Required for Provider-Owned or Controlled Residential Settings
Complete this section only when the individual resides in a setting that is owned or leased by the same party that furnishes HCBS services in that setting. Do not complete if the individual is homeless or in transitional housing.

The individual has a legally enforceable agreement specifying responsibilities and protections from eviction.

10. Does the individual have a legally enforceable agreement such as a lease or resident agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No	11. Does the agreement specify the responsibilities of the individual and the provider with respect to the setting? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	12. Does the agreement specify the circumstances under which the individual's residency may be terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	13. Does the agreement address the steps an individual can follow to request a review or appeal the termination of residency? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
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If yes, complete questions 11-13.

The individual has privacy in his or her sleeping/living unit.

14. Is the individual's living unit configured so that the individual's privacy is protected including when assistance is provided to the individual?
 Yes No

The setting provides living unit doors that are lockable by the individual with only appropriate staff having keys.

15. Can the individual lock his or her door to the unit? <input type="checkbox"/> Yes <input type="checkbox"/> No	16. Does the individual have a key to his or her own living unit? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Individuals sharing units have a choice of roommates in the setting.

17. If the individual does not have his or her own bedroom, does the individual share a bedroom with a roommate of his or her choice?
 Yes No

Individuals have the freedom and support to furnish and decorate their sleeping or living units within the lease or other agreement.

18. Can the individual furnish and decorate his or her unit as they please within the terms spelled out in the legally enforceable agreement?
 Yes No

Individuals' freedom to control schedules and activities and have access to food at any time.		
19. Does the individual control his or her daily schedule without being required to adhere to a set schedule for waking, bathing, eating, exercising, or activities? <input type="checkbox"/> Yes <input type="checkbox"/> No	20. Does the individual have access to typical home areas such as cooking and dining areas, laundry, living and entertainment areas? <input type="checkbox"/> Yes <input type="checkbox"/> No	21. Does the individual have access to food between and after regularly scheduled meal times? <input type="checkbox"/> Yes <input type="checkbox"/> No
The individual is able to have visitors of his or her choosing at any time.		
22. Are visiting hours or the number of visitors allowed at one time determined by the individual? <input type="checkbox"/> Yes <input type="checkbox"/> No	23. If visiting hours are addressed in the legally enforceable agreement, are individuals made aware of limitations before moving into the residential setting? <input type="checkbox"/> Yes <input type="checkbox"/> No	
The setting is physically accessible for each individual.		
24. Are supports to facilitate mobility provided where needed, e.g., home modifications, grab bars, shower seats, or hand rails, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No	25. Are there gates, locked doors, or other barriers preventing access/exit from areas in the setting? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Section III Recommendation

Recommendation (Select one recommendation from the options listed below)	
Private Residence	
<input checked="" type="checkbox"/> The individual resides in a private residence and experiences community integration, privacy, choice, and control. ("Yes" response to question 1, and "Yes" responses to questions 3 through 8 in section 1. Any "No" responses in this section will be resolved through education, referral, and the person-centered planning process.)	
Provider-owned/controlled setting	
<input type="checkbox"/> The individual resides in a provider-owned/controlled setting and experiences community integration, privacy, choice, and control in the setting. ("Yes" response to question 2 in Section 1 and "Yes" responses to questions 3 through 25.)	
<input type="checkbox"/> The individual resides in a provider-owned/controlled setting and does not experience community integration, privacy, choice, and control in the setting. ("Yes" response to question 2 in Section 1 and one or more "No" responses to questions 3 through 25.)	
Homeless (check all that apply)	
<input type="checkbox"/> The individual meets the criteria for homelessness:	
<input type="checkbox"/> Lacking a fixed, regular, and adequate nighttime residence;	
<input type="checkbox"/> Temporarily residing in a supervised publicly or privately operated shelter designed to provide temporary living accommodations of six months or less;	
<input type="checkbox"/> Temporarily residing in a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation.	
Transitional Housing (check one)	
<input type="checkbox"/> The individual resides in a setting that meets one of the following criteria:	
<input type="checkbox"/> Temporary housing and appropriate support services to homeless persons to facilitate movement to independent living;	
<input type="checkbox"/> Housing for individuals recovering from drug addiction that provides an alcohol and drug-free living environment, peer support, assistance with obtaining drug addiction services, and other drug addiction recovery assistance.	

Date Completed 01/16/2020

Signature of individual(s) interviewed (and when applicable, the relationship to the individual)

Philip Weldon

Signature of the Person Completing the form

Hilda Lyatun



Individual Name Philip Weldon

Team Members Participating in Plan Development

Name/relationship	Consumer/guardian/representative	Date	Participation method*
Philip Weldon	Philip Weldon	01/16/2022	In person
Hilda Weldon	Hilda Weldon	01/16/2022	In person
Bob Weldon	Bob Weldon	1-16-2022	In person
Goldie Weldon	Goldie Weldon	1-6-2022	In person

Name/relationship	Consumer/guardian/representative	Date	Participation method*
Name/relationship	Consumer/guardian/representative	Date	Participation method*
Name/relationship	Consumer/guardian/representative	Date	Participation method*
Name/relationship	Consumer/guardian/representative	Date	Participation method*
Name/relationship	Consumer/guardian/representative	Date	Participation method*
Name/relationship	Consumer/guardian/representative	Date	Participation method*

- This plan will be reviewed at least annually and as needed.
 - Recovery manager monitoring will occur according to the schedule on the all service plan.

Please state the reason for this contact/visit

Initial assessment

Specialized Recovery Services (SRS)

Individuals diagnosed with a serious and persistent mental illness, a diagnosed chronic condition, or who are active on the solid organ or soft tissue transplant waiting list may be eligible for the Specialized Recovery Services (SRS) program. Services available through the SRS program include recovery management, individualized placement and support, and peer support. Individuals eligible for the SRS program also receive full Medicaid coverage.

You may be eligible for the SRS program if:

- You have income below \$2,349 per month (\$28,188 per year);
- You are 21 years of age or older;
- You have been diagnosed with a severe and persistent mental illness, are actively on the solid or soft transplant waiting list or have a diagnosed chronic condition, which includes certain malignancies, HIV/AIDS or immune deficiencies, end stage renal disease (ESRD), sickle cell anemia, cystic fibrosis, hemophilia or if you have had a previous organ transplant;
- You need help with medical appointments and/or activities of daily living;
- You have been determined to meet the definition of disability used by the Social Security Administration for purposes of SSI or SSDI (this does not apply if you are under 65 with ESRD, or over 65 with certain diagnosed chronic conditions or actively on the solid or soft transplant waiting list); and
- You do not live in a nursing facility, hospital or similar setting.

If you are eligible, you may get these Medicaid-covered services in addition to your current Medicaid health care coverage:

- Recovery Management - Assistance developing a plan of care specific to your needs
- Individual Placement and Support (IPS) - Supported Employment - Help finding and keeping a job
- Peer Support - Support from others with similar life experiences

SRS Frequently Asked Questions

SRS Consumer Handbook



Have questions?
Call us.

Consumer Hotline:
(800) 324-8680

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Ohio

Department of
Medicaid

Recovery Management Handbook

A resource guide for Ohioans enrolled in
the Specialized Recovery Services program



Your Rights

As an individual enrolled in Ohio Medicaid and the SRS program, you have the right to:

- Be treated with dignity and respect.
- Be protected from abuse, neglect and mistreatment.
- Appoint an authorized representative to act on your behalf.
- Have your Recovery Manager explain what it means to be enrolled in the SRS program and work with you to plan the services you will receive.
- Have private meetings and receive ongoing assistance from your Recovery Manager.
- Be kept informed with material that is accurate and easy to understand.
- Choose Medicaid-approved providers that will provide safe, appropriate and high quality services.
- Speak in confidence and know that your health care information will be kept confidential.
- Request assistance with problems, concerns and issues.
- Access files, records and other information related to your health care.
- Request a change in recovery management contractor or Recovery Manager.
- File a grievance , if on MyCare, or Request a state hearing to appeal any decisions made by your Recovery Manager or Ohio Medicaid about your eligibility or benefits.
- See any files or records related to your health care.
- Be fully informed about how to report any concerns about your Recovery Manager, services or providers to the Ohio Department of Medicaid.

Frequently Asked Questions: Specialized Recovery Services

OHIO DEPARTMENT OF MEDICAID

May 2019

The Specialized Recovery Services (SRS) program was created in August of 2016. SRS covers individuals who have been diagnosed with a severe and persistent mental illness, individuals with a diagnosed chronic condition, or who are active on the solid organ or soft tissue transplant waiting list.

What is the Specialized Recovery Services program?

SRS is a Medicaid program that provides three services that are not available under a traditional Medicaid benefit plan. These services are:

- » Recovery Management - assistance developing a plan of care specific to an individual's needs
- » Individualized Placement and Support - Supported Employment – helping individuals find and keep a job
- » Peer Recovery Support - support from others with similar life experiences.

Who is eligible for the SRS?

SRS is for individuals diagnosed with serious and persistent mental illness, certain chronic conditions*, or who are active on the solid organ or soft tissue transplant waiting list. To be eligible for SRS, the following criteria must also be met:

- » You have income below \$2,313 per month (\$27,756 per year);
- » You are 21 years of age or older;
- » You are actively on the solid or soft transplant waiting list or have a diagnosed chronic condition, which includes certain malignancies, HIV/AIDS or immune deficiencies, end stage renal disease (ESRD), sickle cell anemia, cystic fibrosis, hemophilia or if you have had a previous organ transplant;
- » You need help with medical appointments and/or activities of daily living;
- » You have been determined to meet the definition of disability used by the Social Security Administration for purposes of SSI or SSDI (this does not apply if you are under 65 with End Stage Renal Disease (ESRD), or are over 65 with certain diagnosed chronic conditions or actively on the solid or soft transplant waiting list);
- » You do not live in a nursing facility, hospital or similar setting.

How do I sign up for SRS?

You may ask your health care provider or local county department of job and family services office about SRS and how to apply.

Also, if you have been identified as being potentially eligible for SRS, a recovery manager may contact you. The

recovery manager may ask you about your past and current health care treatment and help you complete an assessment to determine your need for SRS services. The assessment is part of the eligibility determination process.

If I am enrolled in SRS will I keep my other Medicaid benefits?

Yes. If you are eligible for SRS, then you will continue to receive your other Medicaid benefits.

If I am enrolled in SRS can I continue to see my current health care provider(s)?

Yes. Because you will keep your Medicaid coverage, you may continue seeing any of your current Medicaid provider(s). Under SRS you will also meet with a recovery manager to develop a personalized plan of care.

Will new benefits will be offered through the SRS program?

Yes. They include:

Recovery Management*

Recovery managers will work with individuals to develop a comprehensive plan of care. The recovery managers will meet with individuals regularly to monitor their plan and the receipt of their services.

Individualized Placement and Support - Supported Employment (IPS-SE)

Supported employment services can help individuals find a job. A supported employment worker will evaluate an individual's interests, skills, experience, and goals as it relates to employment goals. IPS programs also provide ongoing support to help individuals successfully maintain employment. A job can serve as more than an income. It can also help individuals feel a sense of accomplishment and help them manage their behavioral health issues.

Peer Recovery Support

Peer recovery supporters are people who use their own experiences with mental health and substance use disorders to help individuals reach their recovery goals. Goals are included in a care plan designed by the individual based on his or her preferences and availability of community and natural supports. The peer relationship can help individuals focus on strategies and progress toward self-determination, self-advocacy, well-being and independence.

*If you are eligible for SRS because of a diagnosed chronic condition or because you are on a transplant list you can only receive recovery management services.

Are there any costs associated with the SRS program?

No. There is no cost to apply and there are no co-payments or premiums for the SRS program.

Who can answer my questions about the SRS program?

You can ask your health care provider or your local county department of job and family services or you can call the Medicaid Consumer Hotline at 1-800-324-8680 if you have questions about SRS.

Information may also be found on the Ohio Department of Medicaid website by following this link: <https://medicaid.ohio.gov/FOR-OHIOANS/Programs/Specialized-Recovery-Services>.

Questions?

Contact the Ohio Medicaid Consumer Hotline: 1-800-324-8680

Frequently Asked Questions: Specialized Recovery Services

Ohio Department of Medicaid

Updated: November 2024

What is the Specialized Recovery Services (SRS) Program?

The SRS program currently serves individuals diagnosed with a severe and persistent mental illness (SPMI), a diagnosed chronic condition (DCC), and/or who are active on the solid organ or soft tissue transplant waiting list.

SRS is a Medicaid program that provides two services in addition to Medicaid coverage. These services are:

- **Recovery Management** – assistance developing a plan of care specific to an individual's needs.
- **Individualized Placement and Support - Supported Employment** – helping individuals find and keep a job.

Who is eligible for SRS?

SRS is for individuals diagnosed with severe and persistent mental illness, certain chronic conditions, or who are active on the solid organ or soft tissue transplant waiting list. To be eligible for SRS, the following criteria must also be met:

- The individual must be 21 years of age or older.
- The individual must meet eligibility criteria in Ohio Administrative Code 5160-43-02.
- The individual must have one or more of the medical conditions below (see the SRS Qualifying Diagnosis List for a full list of qualifying medical conditions).
 1. Severe and persistent mental illness, which may include (but is not limited to) bipolar disorder, obsessive-compulsive disorder, schizophrenia, or post-traumatic stress disorder.
 2. Diagnosed chronic condition, which may include (but is not limited to) end-stage renal disease (ESRD), cystic fibrosis, HIV/Aids, or immune deficiencies.
 3. Active status on a solid organ or soft tissue waiting list.
- The individual must need help with medical appointments and/or activities of daily living.
- The individual must have been determined to meet the definition of disability used by the Social Security Administration for purposes of SSI or SSDI.
 - Please note that this requirement does not apply if you are:
 - Under 65 with ESRD.
 - Over 65 with certain DCCs.
 - Actively on the solid or soft transplant waiting list.
 - For more information on how SSA disability is defined, please visit <https://www.ssa.gov>.
- The individual resides in a Home and Community-Based Services setting (as defined in Ohio Administrative Code 5160-44-01).

How do I sign up for SRS?

You may ask your health care provider or local County Department of Job and Family Services office about SRS and the application process. Also, if you have been identified as potentially eligible for SRS, a recovery manager may contact you.

The recovery manager may ask you about your past and current health care treatment and complete an assessment to determine your need for SRS services. The assessment is part of the eligibility determination process.

To submit a SRS application on your own or for another individuals, send a secure email to the SRS@medicaid.ohio.gov mailbox. Please follow the instructions below to provide the required information:

Directions for Establishing a Secure E-mail Connection with the Ohio Department of Medicaid:

1. Access the state's secure e-mail system (Please note: Providers can only use the State secure e-mail system to send secure e-mail to the State of Ohio e-mail addresses).
2. Click the "Register button at the bottom center of the page.
3. Follow the registration directions and establish an account.
4. Log in and use the "Compose" tab to send an SRS referral e-mail or attach a completed SRS referral template to SRS@medicaid.ohio.gov.

The secure email should include:

- Medicaid ID (if already enrolled in Medicaid, members will have a Medicaid ID number identifying them in the Medicaid system. The Medicaid ID number is available on the identification card members receive from their managed care plan).
- Social Security Number.
- Qualifying Diagnosis (a link to the SRS Qualifying Diagnosis List lookup is available at <https://medicaid.ohio.gov/specialized-recovery-services> under the "more information" section).
- Monthly Income (Retirement, Survivors, and Disability insurance (RSDI), Social Security Income (SSI), Pensions, Employment, etc.).
- Name.
- Address.
- Telephone number.
- Gender.
- Whether the individual is scheduled for any surgeries related to their diagnosed chronic condition(s).

If I am enrolled in SRS will I keep my other Medicaid benefits?

If you are eligible for SRS, then you will continue to receive your other Medicaid benefits except for Home and Community-Based Services (HCBS) waiver benefits. You may not be enrolled on an HCBS waiver and SRS at the same time.

If I am enrolled in SRS can I continue to see my current health care provider(s)?

Yes. Because you will keep your Medicaid coverage, you may continue seeing any of your current Medicaid provider(s). Under SRS you will also meet with a recovery manager to develop a personalized plan of care.

Will new benefits be offered through the SRS program?

Yes. They include:

1. Recovery Management*

Recovery managers will work with individuals to develop a comprehensive plan of care. The recovery managers will meet with individuals regularly to monitor their plan and the receipt of their services.

2. Individualized Placement and Support - Supported Employment (IPS-SE)

Supported employment services can help individuals find a job. A supported employment worker will evaluate an individual's interests, skills, experience, and goals as it relates to employment goals. IPS programs also provide ongoing support to help individuals successfully maintain employment. A job can serve as more than an income. It can also help individuals feel a sense of accomplishment and help them manage their behavioral health issues.

***Note:** If you are eligible for SRS because of a diagnosed chronic condition or because you are on a transplant list, you can only receive Recovery Management services. IPS-SE is only currently available to those with a severe and persistent mental illness diagnosis.

Are there any costs associated with the SRS program?

No. There is no cost to apply and there are no co-payments or premiums for the SRS program.

Report : TPL-0030-R
Process : TPLJR030
Location : TPL0030R

MIIS
Medicaid Information Technology System
ESTATE RECOVERY - RECIPIENT DETAIL REPORT
REPORT PERIOD: 04/06/2020

Run Date: 04/06/2020
Run Time: 19:03:25
Page: 2

RECIPIENT NAME: WELDON, PHILIP

RECIPIENT ID NUMBER: 916001652329 ESTATE RECOVERY: 2541846 TRACKING START DATE: 09/23/2011

MANAGED CARE PREMIUM PAYMENTS:

MONTH	TOTAL
02/2020	\$1,785.16
03/2020	\$1,785.16

SUMMARY OF PAYMENTS 53,570.32

LONG TERM CARE PARTNERSHIP PROGRAM PAYMENTS:

MONTH	TOTAL
N/A	N/A

SUMMARY OF PAYMENTS 50.00

END OF RECIPIENT

The Columbus Dispatch

BUSINESS

Ohio's 'free' Medicaid health care program that could claw back money from your estate

Mark Williams The Columbus Dispatch

Published 10:47 a.m. ET Dec. 27, 2021 | Updated 1:56 p.m. ET Dec. 27, 2021

Bob Weldon is on a mission to single-handedly educate consumers about the dangers of a particular Medicaid policy that resulted in the state trying to take thousands of dollars from his brother's estate.

He wants to do that by changing state law.

At issue is Medicaid coverage pitched by state government representatives as free for his brother, who needed health insurance while in a losing fight with cancer.

"The more I read and dig in on this, the more disturbed I get," said Weldon, who owns an insurance agency, Tom Jones Insurance, in Millersport. "I believe there are thousands of people in the state of Ohio who have no idea that the benefits they signed up for are subject to estate recovery."

Weldon's brother, Philip, was diagnosed with cancer in July 2016.

Three years later, as the disease progressed, he had to quit work. He went on Social Security disability, but needed health care coverage.

Bob Weldon, 63, went on the federal health insurance exchange and found a policy for his brother in July 2019. When the policy was renewed in January 2020, the policy costs \$213 a month.

At the same time the policy was being renewed, the Central Ohio Area Agency on Aging reached out to Philip about a Medicaid program called Specialized Recovery Services that assists adults with severe and persistent mental illness, certain diagnosed chronic conditions and those actively waiting on specific transplant lists.

The pitch: The program was free. Beyond offering health care coverage, the program provided extra services such as house cleaning.

Bob Weldon said he was repeatedly assured there was no cost, even as he continued to doubt that was possible.

"Yes, Mr. Weldon, not a dime," he was told.

On Feb. 20, 2020, Fairfield County Job and Family Services told Weldon his brother qualified for the program. The coverage was backdated to Feb. 1.

Weldon canceled his brother's policy on the health care exchange and signed up for the new coverage for his brother, who by this point was in the final stages of his illness. He passed away on March 4, 2020, at the age of 63.

Following his death, the Ohio Attorney General's office placed a claim against the brother's estate for \$3,570, basically for two months of managed care premiums for the time that policy was in effect. As it turned out, the policy that was sold to his brother as being free actually cost \$1,785 a month.

Weldon's brother would have been better off to stick with the policy he had bought on the federal exchange for \$213 a month.

Brother's death launches Ohio Medicaid recovery campaign

Since his brother's death, Weldon has been on a campaign to understand why, in the process of signing up for the policy, he was never told the state could seek to recover those costs from his brother's estate.

"I am absolutely stunned that somebody can get signed up on this and not require a signature of understanding," he said. "I just don't understand that."

Weldon has complained to the Ohio Department of Job and Family Services, the Fairfield County Department of Job and Family Services, the Ohio Department of Aging, local and state politicians, the attorney general's office and others. When he called the state's Medicaid hotline, Weldon complained that that the material he has looked at is deceptive.

Ultimately, the estate settled the bill from the Ohio Attorney General's office for \$426, the price for two months' premiums that Weldon's brother would have paid under the old policy he had on the federal health care exchange.

Weldon has been persistent in his efforts to see the state do something to better inform consumers of the possibility that the state could take money from an estate of someone who was covered under the Specialized Recovery Services program.

He has called on legislators to pass a bill requiring that consumers sign a simple form before receiving benefits that acknowledges that money spent under the program is subject to being recovered from their estate.

"I want a disclosure a fifth-grader could understand," he said. "I want it fixed. ... I believe there's been other people who have been duped.

"I'm tired of people telling me, 'I'm sorry, I can't help you.'"

State Sen. Tim Schaffer, R-Lancaster, has introduced legislation that would require a disclosure.

The simple, one-page bill, Senate Bill 60, would require the Ohio Department of Medicaid to ensure that every applicant for any Medicaid program be notified of the provisions of the state's Medicaid estate recovery program. The legislation is pending in a Senate committee.

The Medicaid estate recovery program allows the state to obtain repayment for the cost of Medicaid benefits once a Medicaid-eligible person dies. Recovery happens after the death of a Medicaid recipient who was either permanently institutionalized or 55 or older and not in an institution.

The Ohio Attorney General's office recovered \$57.7 million for its 2020 fiscal year, the most recent year available.

"This is an issue that was brought to my attention when it impacted a family in my district, and it was clear that legislative action was necessary since this issue has gone unresolved," Schaffer said in a statement. "Since introducing Senate Bill 60, I have had numerous conversations with the Ohio Department of Medicaid to address this important issue, and I am actively working with the department to find a suitable remedy."

The Department of Medicaid says it is stepping up its efforts to heighten visibility and awareness of the Medicaid estate recovery policy.

This includes revising notices that it provides to applicants and updating the language used online that is available to everyone who is applying for Medicaid eligibility. The changes go into effect in March.

It also includes strengthening training for county Job and Family Service caseworkers who manage and process Medicaid applications to ensure the process informs applicants of the estate recovery policy.

The Ohio Medicaid website also includes information being displayed more prominently to increase awareness of the estate recovery provision by using plain language.

"I'd love for there to be lot more knowledge about this out there," said Keith Stevens, an elder law attorney with the firm Carlile Patchen & Murphy.

Still, Stevens said he's not sure how much it will help in the midst of all the paperwork that is put before applicants seeking Medicaid coverage.

"It is something pretty easy to overlook," he said.

Some of the confusion may stem from third parties that may tell clients that the service is free because there aren't fees on their end, he said.

Still, more than one client has been surprised when the state has filed a claim against an estate over Medicaid costs, Stevens said.

Weldon is sticking with his demand that consumers sign a simple, easy-to-understand document.

"What they have is a process in place that has failed for years and years," he said. "I will not accept anything other than a signature of understanding."

mawilliams@dispatch.com

@BizMarkWilliams

Bob Weldon

From: Williams, Mark <mawilliams@dispatch.com>
Sent: Tuesday, January 11, 2022 8:17 AM
To: Bob Weldon
Subject: Fw: 12 29 2021 Article about Medicaid/SRS

Flag Status: Flagged

This one from today

Mark Williams
Business Reporter
Columbus Dispatch
mawilliams@dispatch.com
740-438-4259 (cell)

From: Kathleen Koch <kkoch48@gmail.com>
Sent: Monday, January 10, 2022 10:18 PM
To: Williams, Mark <mawilliams@dispatch.com>
Subject: 12 29 2021 Article about Medicaid/SRS

Hello Mark

I read your article with great interest. I was approved for the SRS program because my social security benefits are minimal. I learned about this program from a social worker at the Cleveland Clinic while seeking approval for a kidney transplant. The social worker suggested that I might want to apply because the anti-rejection drugs are not covered by my insurance. During the application process, no mention was made of "pay back" from my estate.

Do you have any further information as to whom I might contact to get further information about this. I am quite disturbed by this information. I don't question the validity, but want to delve further into this.

Thank you for your time.

Kathleen A Koch

Bob Weldon

From: Teresa Head-Gordon <thg@berkeley.edu>
Sent: Wednesday, January 5, 2022 6:11 PM
To: Bob Weldon
Subject: Re: Medicaid recovery
Attachments: Hill MITS.pdf

Flag Status: Flagged

Dear Bob,

Thank you for your extensive research and very helpful directions. Our probate attorney is going to formally reject the Medicaid claim and there will likely be a hearing where we will protest this egregious predatory practice perpetuated against innocent people like my mother.

The deceptive language on our end is that ^{MY CARE} PASSPORT is a Ohio program that "keeps senior's in their home and community, and supporting their independence so they do not need to go into assisted/institutionalized settings."

I attach the itemized "services" provided to my mother at ~\$3700 a month for "managed care". Managed care for a women who never spent a day in the hospital until her last month, who drove her own leased vehicle, did her own shopping, cleaned her own house, and cooked dinner for herself and others. They installed shower bars in her 1 bathroom and provided her with small packaged meals for breakfast (which she accepted as part of the program since it was "free").

I am going to write to a few academics, and other ways to start getting this largely known to as many people as possible. I will also be writing to congress, etc.

Talk again soon.

Thanks, Teresa

Professor Teresa Head-Gordon
Chancellor's Professor
Departments of Chemistry, Bioengineering, Chemical & Biomolecular Engineering University of California, Berkeley
Faculty Scientist Chemical Sciences Division, Lawrence Berkeley National Laboratory
510-666-2744
thg@berkeley.edu

On 1/5/22 11:48 AM, Bob Weldon wrote:

> Teresa,
>
> Thank you for reaching out.
>
> My cell phone is 740-503-8181.
>
> Would it be possible for you to send me the copy of the bills for your mother?
>
> I wish I would been able to have a conversation with you before I went to Senator Schaffer.
>

Report :
Process :
Location :

MITS
Medicaid Information Technology System
ESTATE RECOVERY - RECIPIENT DETAIL REPORT
REPORT PERIOD: 01/03/2022

Run Date: 01/03/2022
Run Time: 19:06:51
Page: 2

RECIPIENT NAME:

RECIPIENT ID NUMBER:

STATE RECOVERY:

TRACKING START DATE: 03/21/1993

BUYIN PREMIUM PAYMENTS:

MONTH	PART A PREMIUM PAID	PART B PREMIUM PAID	TOTAL
07/2009	50.00	\$385.60	\$385.60
08/2009	50.00	\$96.40	\$96.40
09/2009	50.00	\$96.40	\$96.40
10/2009	50.00	\$96.40	\$96.40
11/2009	50.00	\$96.40	\$96.40
12/2009	50.00	\$96.40	\$96.40
SUMMARY OF PAYMENTS			\$867.60

MANAGED CARE PREMIUM PAYMENTS:

MONTH	TOTAL
02/2017	\$3,743.73
03/2017	\$3,743.73
04/2017	\$3,743.73
05/2017	\$3,743.73
06/2017	\$3,743.73
07/2017	\$3,513.21
08/2017	\$3,513.21
09/2017	\$3,513.21
10/2017	\$3,513.21
11/2017	\$3,513.21
12/2017	\$3,513.21
01/2018	\$3,373.00
02/2018	\$3,373.00
03/2018	\$3,373.00
04/2018	\$3,373.00

Report :
Process :
Location :

MITS
Medicaid Information Technology System
ESTATE RECOVERY - RECIPIENT DETAIL REPORT
REPORT PERIOD: 01/03/2022

Run Date: 01/03/2022
Run Time: 19:06:51
Page: 3

RECIPIENT NAME: HILL, BETTY

RECIPIENT ID NUMBER:

ESTATE RECOVERY:

TRACKING START DATE: 03/21/1993

05/2018	\$3,373.00
06/2018	\$3,373.00
07/2018	\$3,394.79
08/2018	\$3,394.79
09/2018	\$3,394.79
10/2018	\$3,394.79
11/2018	\$3,394.79
12/2018	\$3,394.79
01/2019	\$3,525.24
02/2019	\$3,525.24
03/2019	\$3,525.24
04/2019	\$3,525.24
05/2019	\$3,525.24
06/2019	\$3,525.24
07/2019	\$3,620.19
08/2019	\$3,620.19
09/2019	\$3,620.19
10/2019	\$3,620.19
11/2019	\$3,620.19
12/2019	\$3,620.19
01/2020	\$3,532.96
02/2020	\$3,532.96
03/2020	\$3,532.96
04/2020	\$3,532.96
05/2020	\$3,532.96
06/2020	\$3,532.96
07/2020	\$3,581.98
08/2020	\$3,581.98
09/2020	\$3,581.98
10/2020	\$3,581.98
11/2020	\$3,581.98
12/2020	\$3,581.98
01/2021	\$3,562.49

Report :
Process :
Location:

MITS
Medicaid Information Technology System
ESTATE RECOVERY - RECIPIENT DETAIL REPORT
REPORT PERIOD: 01/03/2022

Run Date: 01/03/2022
Run Time: 19:06:51
Page: 4

RECIPIENT NAME: HILL, BETTY

RECIPIENT ID NUMBER:

ESTATE RECOVERY:

TRACKING START DATE: 03/21/1993

02/2021	\$3,562.49
03/2021	\$3,562.49
04/2021	\$3,562.49
05/2021	\$3,562.49
06/2021	\$3,562.49
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SUMMARY OF PAYMENTS 5187,341.81

LONG TERM CARE PARTNERSHIP PROGRAM PAYMENTS:

MONTH	TOTAL
-----	-----
N/A	N/A
-----	-----

SUMMARY OF PAYMENTS \$0.00

END OF RECIPIENT

I received a phone call from Robin who lives in Hebron, Ohio.

He had moved in with his father to help take care of him.

His father stated that he would inherit that house after he passed.

Robin is a contractor and out of his pocket he put about \$40,000 of materials and time in the house prior to his father's passing.

His father passed and the estate received a bill for \$110,000.

He stated that he was certain that his father did not know that his Medicaid came with payback.

Question. How does that happen?

My friend and client Susan's story.

Her husband had a stroke. He was taken to the VA hospital and then to a rehabilitation facility.

She received a phone call one day and they told her that he was coming home and when she went to work a nurse would show up and stay with her husband while she was at work.

Susan told me that she knew that he was on Medicaid.

10 years later her husband passed, and she received a notice that \$360,000 was do.

She now has a lien on her house.

Question. How does that happen?

Ohio Revised Code

5162.21

Ohio Medicaid Recovery Notifications

ODM 07400

Renewal application

Audio Intake application

Rule 5160:1-2-01 Ohio Administrative Code

5162.21 Medicaid estate recovery program..

(A) As used in this section and section 5162.211 of the Revised Code:

(1) "Estate" includes both of the following:

(a) All real and personal property and other assets to be administered under Title XXI of the Revised Code and property that would be administered under that title if not for section 2113.03 or 2113.031 of the Revised Code;

(b) Any other real and personal property and other assets in which an individual had any legal title or interest at the time of death (to the extent of the interest), including assets conveyed to a survivor, heir, or assign of the individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(2) "Institution" means a nursing facility, ICF/IID, or a medical institution.

(3)

"Permanently institutionalized individual" means an individual to whom all of the following apply:

(a) Is an inpatient in an institution;

(b) Is required, as a condition of the medicaid program paying for the individual's services in the institution, to spend for costs of medical or nursing care all of the individual's income except for an amount for personal needs specified by the department of medicaid;

(c) Cannot reasonably be expected to be discharged from the institution and return home as determined by the department of medicaid.

(4) "Qualified state long-term care insurance partnership program" means the program established under section 5164.86 of the Revised Code.

(5) "Time of death" shall not be construed to mean a time after which a legal title or interest in real or personal property or other asset may pass by survivorship or other operation of law due to the death of the decedent or terminate by reason of the decedent's death.

(B) To the extent permitted by federal law, the department of medicaid shall institute a medicaid estate recovery program under which the department shall, except as provided in divisions (C) and (E) of this section, and subject to division (D) of this section, do all of the following:

(1) For the costs of medicaid services the medicaid program correctly paid or will pay on behalf of a permanently institutionalized individual of any age, seek adjustment or recovery from the individual's estate or on the sale of property of the individual or spouse that is subject to a lien imposed under section 5162.211 of the Revised Code;

(2) For the costs of medicaid services the medicaid program correctly paid or will pay on behalf of an individual fifty-five years of age or older who is not a permanently institutionalized individual, seek adjustment or recovery from the individual's estate;

(3) Seek adjustment or recovery from the estate of other individuals as permitted by federal law.

(C)

(1) No adjustment or recovery may be made under division (B)(1) of this section from a permanently institutionalized individual's estate or on the sale of property of a permanently institutionalized individual that is subject to a lien imposed under section 5162.211 of the Revised Code or under division (B)(2) or (3) of this section from an individual's estate while either of the following are alive:

(a) The spouse of the permanently institutionalized individual or individual;

(b) The son or daughter of a permanently institutionalized individual or individual if the son or daughter is under age twenty-one or, under the "Social Security Act," section 1614, 42 U.S.C. 1382c, is considered blind or disabled.

(2) No adjustment or recovery may be made under division (B)(1) of this section from a permanently institutionalized individual's home that is subject to a lien imposed under section 5162.211 of the Revised Code while either of the following lawfully reside in the home:

(a) The permanently institutionalized individual's sibling who resided in the home for at least one year immediately before the date of the permanently institutionalized individual's admission to the institution and on a continuous basis since that time;

(b) The permanently institutionalized individual's son or daughter who provided care to the permanently institutionalized individual that delayed the permanently institutionalized individual's institutionalization and resided in the home for at least two years immediately before the date of the permanently institutionalized individual's admission to the institution and on a continuous basis since that time.

(D) In the case of a participant of the qualified state long-term care insurance partnership program, adjustment or recovery required by this section may be reduced in accordance with rules authorized by division (G) of this section.

(E) The department shall, in accordance with procedures and criteria established in rules authorized by division (G) of this section, waive seeking an adjustment or recovery otherwise required by this section if the medical director determines that adjustment or recovery would work an undue hardship. The department may limit the duration of the waiver to the period during which the undue hardship exists.

(F) For the purpose of determining whether an individual meets the definition of "permanently institutionalized individual" established for this section, a rebuttable presumption exists that the individual cannot reasonably be expected to be discharged from an institution and return home if either of the following is the case:

(1) The individual declares that he or she does not intend to return home.

(2) The individual has been an inpatient in an institution for at least six months.

(G) Rules adopted under section 5162.02 of the Revised Code shall do both of the following:

(1) For the purpose of division (D) of this section and consistent with the "Social Security Act," section 1917(b)(1)(C), 42 U.S.C. 1396p(b)(1)(C), provide for reducing an adjustment or recovery in the case of a participant of the qualified state long-term care insurance partnership program;

(2) For the purpose of division (E) of this section and consistent with the standards specified by the United States secretary of health and human services under the "Social Security Act," section 1917(b)(3), 42 U.S.C. 1396p(b)(3), establish procedures and criteria for waiving adjustment or recovery due to an undue hardship.

Renumbered from § 5111.11 by 130th General Assembly File No. 25, HB 59, §101.01, eff. 9/29/2013.

Effective Date: 08-29-2000; 06-30-2005; 06-30-2006; 2007 HB119 09-29-2007.

6/10/2020

Lawriter - ORC - 5164.86 Qualified state long-term care insurance partnership program..

5164.86 Qualified state long-term care insurance partnership program..

The medical director shall establish a qualified state long-term care insurance partnership program consistent with the definition of that term in the "Social Security Act," section 1917(b)(1)(C)(iii), 42 U.S.C. 1396p(b)(1)(C)(iii). An individual participating in the program who is subject to the medical estate recovery program instituted under section 5162.21 of the Revised Code shall be eligible for the reduced adjustment or recovery under division (D) of that section.

Renumbered from § ~~5111.18~~ by 130th General Assembly File No. 25, HB 59, §101.01, eff. 9/29/2013.

Effective Date: 06-30-2006 .

4

Ohio Department of Medicaid
OHIO MEDICAID ESTATE RECOVERY

What is estate recovery?

Estate recovery seeks to obtain repayment for the cost of Medicaid benefits once a Medicaid eligible individual is deceased. This happens after the death of a Medicaid individual who was either permanently institutionalized or age 55 and older.

This is an incomplete statement.

What is an estate?

An estate is all of the real and personal property owned by a Medicaid individual at the time of death, whether or not it passed through probate court.

What Medicaid benefits are subject to estate recovery?

Medicaid payments for services received since January 1995 are subject to estate recovery. Medicare premium assistance payments made after January 1, 2010, are subject to recovery only when the Medicaid individual was permanently institutionalized.

How does estate recovery work?

The estate's executor is responsible for notifying the Ohio Attorney General's Office (AGO) of a Medicaid individual's death, if the individual was permanently institutionalized or age 55 or older. Once the AGO has been notified, the AGO will present a claim to the estate.

When does estate recovery take place?

Recovery from the estate will only be made:

- ❖ After the death of the Medicaid individual's surviving spouse.
- ❖ When the deceased Medicaid individual has no surviving child younger than age 21.
- ❖ When the deceased Medicaid individual has no surviving child of any age who is considered blind or disabled under Medicaid regulations.

Does a will protect assets from estate recovery?

No. Ohio's Medicaid program and other creditors are paid before any assets are distributed to heirs or other beneficiaries.

Are there exceptions to estate recovery?

If there is an undue hardship to a survivor, the right to immediate recovery may be delayed or waived. Undue hardship is determined on a case-by-case basis.

Is a person's house subject to estate recovery?

Yes. A Medicaid individual's house may be subject to estate recovery. If the Medicaid eligible individual was permanently institutionalized, any claim from the sale of a house may be delayed while the individual's sibling or child resides in the home, if specific conditions are met.

Will the Attorney General's Office contact the family of the deceased?

After a Medicaid individual dies, the AGO will send a notice of claim to the estate's executor requesting repayment for the cost of Medicaid benefits. It is the estate executor's responsibility to notify any family members or other heirs who might be affected by the estate recovery. If the estate executor has not been identified to the AGO, the AGO may need to contact the Medicaid individual's family members.

How can the Attorney General's Office be reached?

The Medicaid Estate Recovery Unit of the AGO can be contacted at:

Medicaid Estate Recovery Unit
150 East Gay Street, 21st Floor
Columbus, Ohio 43215-3130

Information can be obtained online at <http://www.ohioattorneygeneral.gov/Business/Collections> or by calling the Ohio Medicaid Consumer Hotline at 1-800-324-8680, or by calling your local County Department of Job & Family Services.

Instructions to CDJFS: In Journal Notes, record the date that this form was given or mailed to the consumer.

NO WHERE DO I FIND A STATEMENT " THE PREMIUM PAYMENTS MADE TO THE MANAGED CARE ORGANIZATION ARE INCLUDED EITHER IN WHOLE OR IN PART IN THE CLAIM AGAINST THE ESTATE."

9

Read and sign this application

Renewal of coverage in future years

Read the following statement and check one box: To make it easier to electronically verify my income at renewal time, I give the Ohio Department of Medicaid permission to use computer data information from my federal tax returns, provided by the IRS, for the number of years I checked below. I understand that the Ohio Department of Medicaid will send me the information it has verified and I will have a chance to correct and update this information. I can also change my mind, at any time, and not allow the Ohio Department of Medicaid to check this information.

Yes, I give permission to use computer data information from my federal tax returns, provided by the IRS, to electronically verify my income for (check one box):

- 5 years (the longest time)
 4 years
 3 years
 2 years
 1 year
 No, I do not give permission to use my tax returns.

Your rights and responsibilities

- I am signing this renewal form under penalty of perjury which means I have provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.
- I know that I must tell the Ohio Department of Medicaid if anything changes (and is different from) what I wrote on this form. I can call (844) 640-6448 to report any changes within 10 days. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I understand that the Ohio Department of Medicaid will get information about my financial resources from banks, credit unions, or other financial institutions in order to determine my eligibility for medical assistance. Authorization to get this information remains in effect until:
 - My application for medical assistance is denied; or
 - My eligibility for medical assistance ends; or
 - I inform the Ohio Department of Medicaid in writing that I wish to end my authorization.
- If I refuse to authorize the Ohio Department of Medicaid to get information about me from financial institutions, or I decide to end my authorization, I understand that my medical assistance may be denied or discontinued.

If anyone on this application is eligible for Medicaid

- I am giving the Ohio Department of Medicaid our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving the Ohio Department of Medicaid our rights to pursue and get medical support from an ex-spouse or parent.
- Does any child on this renewal form have a parent living outside of the home? Yes No
 - If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.
- I understand that when I send in this form, it means I have permission from everyone whose information is on the form to submit their information to Ohio Department of Medicaid and receive any communications about their eligibility and enrollment.

- I authorize any person who furnishes health care or medical supplies or services to give the Ohio Department of Medicaid, the Ohio Department of Job & Family Services, or the Ohio Department of Health any information related to the extent, duration, and scope of services provided under the Medicaid program, WIC, and other medical assistance programs. I also authorize the previously mentioned departments to exchange any information I have provided on this form, to enable the departments to determine my eligibility.
- I understand that if I do not qualify for Medicaid, the Ohio Department of Medicaid may send my information to another program so they can see if I qualify.
- The Ohio Department of Medicaid will check my answers using information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration, the Department of Homeland Security and others. If the information does not match, the Ohio Department of Medicaid may ask me to send more information.
- I understand that, after my death, Ohio Department of Medicaid can file a claim against my estate to recover money that the state paid for coverage provided to me. This process must happen if I am in a medical institution and not expected to return home, or if I am 55 years of age or older and the state pays for my nursing facility services, home and community based services, or related hospital and prescription drug services. The amount recovered by the Ohio Department of Medicaid will not be more than the amount Medicaid paid for my care.
- I understand that the Ohio Department of Medicaid is authorized to collect information on this form, and other supporting information including Social Security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care Education Reconciliation Act of 2010 (Public Law 111-152) and the Social Security Act.

My right to appeal

If I think that the Ohio Department of Medicaid or the Health Insurance Marketplace has made a mistake I can appeal its decision. To appeal means to tell someone at the Ohio Department of Medicaid or the Health Insurance Marketplace that I think the action is wrong and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Ohio Department of Medicaid at (844) 640-6448. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Sign and date below. If you want an authorized representative or want to change the authorized representative you have now, fill out Attachment A on page 10. The last page is a Voter Registration Form and is not part of your Medicaid renewal. If you wish to register to vote, fill that form out and return it separately to your county board of elections.

Check here if you are an authorized representative. Sign below and fill out Attachment A on page 10.

Signature of household contact or authorized representative:

Date:

MEDN11221X00245060500



Audio Signature Script
Medicaid Application (Intake)

Staff must read all content (as applicable) in green
System automatically plays content in blue
Script decision / logic points are in yellow
System / Finesse actions required are in red

Audio signature script begins below:

Once I obtain your name, address and signature over the phone, this application for assistance will be dated XX/XX/XXXX. You have the right to authorize another person to act on your behalf and will have a chance to add an authorized representative during this call. Are you calling to apply for yourself?

[If YES, proceed to IF Caller is Applicant Section below]

[If NO, continue here and ask individual to identify himself or herself]

If you are the authorized representative but have not yet been designated in writing by the applicant, you will need to apply online or submit a paper application at your local JFS office unless the applicant is with you on this call. If you are calling today on behalf of an individual and they are with you, the individual can designate you as the authorized representative on this call and written authorization is not required. Are you calling as an authorized representative?

[If NO, advise the caller that we will not be able to continue because an application is required to be submitted by the applicant or authorized representative.]

[If YES, determine if there is already written authorization to represent in the case record or if the applicant is on the call.]

[If YES to authorization in writing, proceed.]

[If YES to applicant also on call] Ask applicant to identify himself or herself and to confirm the caller can speak on their behalf during the call and that they intend to designate the caller as their authorized representative during the application process. Then state the following to the applicant:

You will need to provide your telephonic signature at the end of this call to officially designate the caller as your authorized representative and to submit your application.

[If NO, advise caller that he or she must:

apply online at ohiobenefits.ohio.gov or submit a paper application at the local JFS office.]

If Caller is Applicant

Page 3 Page 4

Please listen to the brief description of our programs. After each description of the program you will be asked if you would like to apply for this program. Only programs that you say "yes" to will be reviewed for eligibility:

- Cash assistance programs include the Ohio Works First and Refugee Cash Assistance programs. To qualify you must either have a minor child(ren), be at least 6 months pregnant or be a refugee who is within 8 months of arrival. You will get an answer about your application within 30 days. Would you like to apply for Cash assistance? [YES/NO]. [AFTER ANSWERING PROCEED TO NEXT PARAGRAPH].
- The Supplemental Nutrition Assistance Program, also known as SNAP and formerly known as Food Assistance, helps people afford healthy food. To qualify, you must meet certain financial and non-financial requirements. You will get an answer about your application within 30 days. During the interview you will be asked a series of questions to help determine your eligibility for assistance as well as questions to see if you are eligible to receive SNAP benefits within 7 days. Would you like to apply for SNAP? [YES/NO]. [AFTER ANSWERING PROCEED TO NEXT PARAGRAPH].
- Medical assistance includes Medicaid, the Children's Health Insurance Program (CHIP), Medicare Premium Assistance Programs (MPAP), and payment for Long-Term Services and Supports (LTSS). To qualify, you must meet certain financial and non-financial requirements. You will get an answer about your application within 90 days if you're applying because you have a disability, and 45 days if you don't have a disability. Would you like to apply for medical assistance? [YES/NO].

Let's continue with the questions needed to complete the interview and determine eligibility. A summary will be repeated back to you at the end of the call. You must confirm the information is correct in order for this to be considered your application.

Worker conducts interview.

The following will be recorded and serve as your application for benefits. You always have the right to submit an application in writing; however, once your telephone application is submitted over the phone, it will be treated exactly the same as a written application. We will now begin recording...

Start Recording (click Audio Signature button to begin)

If you are not registered to vote where you live now, would you like to apply to register to vote? [YES/NO].

Continue Recording (click Audio Signature button again to continue)

* If you said "YES", a voter registration form will be sent to you following this interview. Follow the instructions on the form once received. If you said "NO", you will be considered to have decided not to register to vote at this time.

By signing this application over the phone, you are certifying under penalty of perjury that the information or answers you provide for yourself and for everyone in your household in this application, during the interview, or in any reported change are complete and accurate to the best of your knowledge, including information provided about the citizenship status for each household member applying for benefits.

By completing this application over the phone, you are confirming that you understand the following:

* Your right to:

Receive fair treatment without regard to race, color, national origin, sex, age, sexual orientation, gender identity (including gender expression), disability, marital status, family/parental status, income derived from a public assistance program, reprisal or retaliation for prior civil rights activity, and in some cases, religion or political beliefs because this institution is an equal opportunity provider; and,

Request a fair hearing if you disagree with any action on your application by calling or writing your local county agency. Your fair hearing will be heard before the Ohio Department of Job and Family Services.

Your responsibility:

- Provide proof that you are eligible.
- Report a change within 10 days if anything changes (or is different than) what you said in this application. A change in your information may affect the eligibility for you or members of your assistance group.
- Understand and agree to provide documents to prove what you say during this call.
- Understand that the county agency may contact other persons or organizations to obtain the necessary proof of your eligibility and level of assistance and/or in some instances, you may be asked to give consent to the county agency to make those contacts.
- Provide Social Security numbers and identify if someone is a US citizen for anyone who is applying for cash and SNAP.
- Understand that Title VI of the Civil Rights Act of 1964 allows us to ask for racial/ethnic (Hispanic or Latino) information. Providing this information is voluntary and is used for informational purposes only. If you do not want to give us the information, it will have no effect on your case but we will enter a response for you.
- Understand that a telephonic signature has the same legal effect and can be enforced in the same way as a written signature.

- Understand that by signing this application and receiving Medicaid, you are assigning to the State of Ohio any rights to medical support and any rights to payments by a liable third party for medical assistance owed to you and/or to any minor child in your assistance group. You understand that you must tell the Ohio Department of Medicaid about any health insurance you have or about any third party responsible for your medical expenses. You give the Department the right to pursue medical support from an ex-spouse or parent. If you think that cooperating to collect medical support will harm your children or yourself, you can tell the Department and you may not have to cooperate.
- Understand that the Ohio Department of Medicaid will get information about your financial resources from banks, credit unions, or other financial institutions to determine your eligibility for medical assistance. Authorization to get this information remains in effect until: your application for medical assistance is denied, your eligibility ends, or you decide to end your authorization. If you refuse to authorize the release of this information, or you decide to end your authorization, you understand that your medical assistance may be denied or discontinued.
- Understand that the Ohio Department of Medicaid will check your answers using Social Security numbers and information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration (SSA), the Department of Homeland Security, and others. If the information does not match, you understand the Ohio Department of Medicaid may ask you to send more information.
- Understand that if you are permanently institutionalized or age 55 or older when you receive Medicaid benefits, the Estate Recovery Program may recover payments for the cost of your care paid by Medicaid from your estate. The cost of your care may include the capitation payment that Medicaid pays to your managed care plan, even if the capitation payment is greater than the cost of the services you actually received.
- Understand that you authorize any person who furnishes health care, medical supplies, or services to give the Ohio Department of Medicaid, the Ohio Department of Job and Family Services, or the Ohio Department of Health any information related to the extent, duration, and scope of services provided under the Medicaid program, WIC, and other medical assistance programs. You also understand that you authorize the previously mentioned departments to exchange any information you have provided to enable the departments to determine your eligibility for medical assistance benefits.

Read one of the following:

If ONLY the Applicant is completing the application:	If Authorized Representative (already designated in writing) is completing the application:
<i>What is your first and last name?</i>	<i>What is your first and last name?</i>
<i>What is your address?</i>	<i>What is the first and last name of the person you are applying for?</i>
<i>Would you like to add an authorized representative? [YES/NO]</i>	

<ul style="list-style-type: none"> • [If YES] What is the Authorized Representative's name? • What is the Authorized Representative's address? <p>[If NO, proceed]</p>	<p>What is your address?</p> <p>What is the address of the person you are applying for?</p>
---	---

I will now read a summary of the information you have provided and record your verbal signature. You will be read a list of statements and after these statements have been read, you will be asked to confirm that you agree with and understand the statements. This is done to confirm what you said and make sure you understand everything we have discussed. Please listen carefully and let me know if the information needs to be changed.

[When an applicant is designating an authorized representative during the call and that person is also on the phone with the applicant, the applicant must answer the following questions to officially designate the person as an authorized representative and to complete the application.]

- **You have requested the following programs:**
[Insert appropriate program(s)]
- **Your application is based on a reported household size of [#] people, which includes [Name(s) of individuals].**
- **[If the household does not claim to be homeless] Your home address is [Insert home address] and your mailing address is [The same as your home address OR Insert other mailing address] in [Insert county] County, Ohio.**
- **[Only read if the household claims to be homeless] You have reported that you do not have a home address and wish to receive mail at [Insert mailing address].**
- **You reported that your household has [Earned/Unearned income] in the monthly amount of [Insert monthly amount] from [Source of income].**
- **You reported your household currently pays the following: [Insert applicable deduction amounts for Rent/Mortgage, Utilities, Medical Expenses, Child or Dependent Care Costs or Child Support Payments].**
- **You have reported [NO] resources OR Resources in the amount of [Insert resources amount] from [Source of resources].**
- **[Only read if an authorized representative is designated during the call]. You have named [Insert name] as your authorized representative on this call.**

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Medicaid Eligibility Manual Table of Contents

John R. Kasich, Governor

John B. McCarthy, Director

Ohio Department of Medicaid

Mission: To improve Medicaid eligibility policy through quality research and collaboration with stakeholders.

The Electronic Publishing Unit makes every attempt to publish accurate and current information, however, we disclaim any liability or responsibility for any typographical errors, out of date information and/or other inaccuracies that may appear in this document.

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eManual Contents		
<i>Please send comments to ePubs_updates@jfs.ohio.gov</i>		
<u>Recent Additions</u>	<u>MEM Transmittal Letter</u>	<u>MEMM Transmittal Letter</u>
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<u>ODM Forms</u>	<u>Other Agency Forms</u>	<u>Sample Forms</u>
<u>Desk Aids</u>	<u>Contact Us</u>	

Recent Additions

To receive eMail notifications of policy updates, go to the **ODM Email List Sign-up site** (<http://www.medicaid.ohio.gov/HOME/ODMEmailListSignup.aspx>) and subscribe to the type of communications in which you are interested. eMail notifications are sent as updates are posted to the eManuals site.

MEMMTL 6 (Medicaid: Presumptive Eligibility) (4/27/15)

MEMTL 98 (Medicaid: Eligibility through the Spenddown Process) (3/27/15)

MEMTL 101 (Medicaid: Eligibility Chapter Five) (3/25/15)

MEMTL 100 (Medicaid: Eligibility Chapter 4) (3/25/15)

MEMTL 99 (Medicaid: Application for Home and Community-Based [HCB] Services) (3/25/15)

MEPL 99 (Medicaid: 2015 Federal Poverty Level Income Guidelines for MBIWD) (3/12/15)

MEPL 98 (Medicaid: 2015 Federal Poverty Level Income Guidelines for Low-Income MPAP) (3/12/15)

MEMTL 60 (Medicaid Estate Recovery)

Medicaid Eligibility Manual Transmittal Letter No. 60

December 16, 2009

To: All Medicaid Eligibility Manual Holders
From: Douglas E. Lumpkin, Director
Subject: Medicaid Estate Recovery

This MEMTL contains one rule from Chapter 5101:1-38 of the Administrative Code. Rule **5101:1-38-10** "Medicaid estate recovery", adopted under section 119.03 of the Revised Code, replaces former rule 5101:1-38-10 of the Administrative Code.

The effective date of this rule is January 1, 2010.

Chapter 2

5101:1-38-10 Medicaid Estate Recovery

This rule is amended due to Section 115 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), which changed federal estate recovery provisions. Medicare cost-sharing benefits paid after January 1, 2010, are not subject to estate recovery if the consumer was not permanently institutionalized. This exception was added to paragraph (C)(2), which addresses estate recovery for individuals who are fifty-five years of age or older and who are not permanently institutionalized.

Forms *IN THE ODM 07400 OR JFS 07400 DOES ONE FIND THIS LAST SENTENCE?*

JFS 07400 "Ohio Medicaid Estate Recovery"

The Ohio Medicaid Estate Recovery fact sheet, form JFS 07400, has been revised to reflect the exclusion of cost-sharing benefits paid after January 1, 2010, from estate recovery if the individual was not permanently institutionalized. *Where on the form state the exception?*

The signature block has been removed because, while federal regulations require counties to notify consumers of Estate Recovery, there is no requirement that a signature be obtained. Compliance with this requirement can be met by documenting in the electronic eligibility system the date that this form was provided to the consumer. *TERRIBLE BUSINESS PRACTICE!!*

MEM Instructions:

Location	Remove	Replace
Chapter 2	5101:1-38-10 (Effective 9/1/2007)	5101:1-38-10 (Effective 1/1/2010)
Forms	JFS 07400 (Rev. 6/2007)	JFS 07400 (Rev. 9/2009)

This information is also available on the Internet and may be accessed at:

ODJFS Electronic Manuals

<http://emanuals.odjfs.state.oh.us/emanuals/>

InnerWeb Calendar:

<http://www.odjfs.state.oh.us/lpc/calendar/staff/>

Internet Calendar:

<http://www.odjfs.state.oh.us/lpc/calendar/>

Bob Weldon

From: Colin.Phillips@ohiosenate.gov
Sent: Tuesday, April 12, 2022 5:22 PM
To: 'Bob Weldon'
Subject: FW: When the signature block was removed from the JFS 07400
Attachments: ODM 07400 REV 06.2007.pdf

Flag Status: Flagged

Bob,

See the below response from Steven at Medicaid.

I will let you know when he gets the rest of the info to me.

Best,
Colin M. Phillips

Hi Colin,

I am still waiting to find out the percent of applicants who apply by phone, but I can share with you what I've found regarding the other questions.

I was able to find the form prior to 2010 for you, but it did take some digging. Anecdotally, I was able to learn that at the time, the form was not required to be signed even though it did have a signature block on the form. This is most likely for the same reasons as I outlined in the summary from our legal staff. Counties were required to ensure that applicants were informed of estate recovery as they are now. It's been more than a decade and 3 administrations, so I'm not 100% why the change was made, but it sounds like it was most likely done to conform with federal templates.

There are no other entities that can enroll Medicaid individuals other than county and state officials. That's a federal requirement. Individuals can enroll online via the self-service portal without a direct contact from a county worker. That is why updating the disclosure there was so important. Certain entities like FQHCs and hospitals can enroll people in Medicaid for presumptive eligibility. This is only a temporary benefit, and is not considered full Medicaid enrollment. It's not subject to estate recovery.

Regarding the use of a handbook, I was informed that there used to be a Medicaid Eligibility Manual, but it was replaced with just using the OAC code sections themselves. As for the question regarding a section that speaks to county requirements for notifying individuals of estate recovery when applying, that can be found in 5160:1-2-01(D)(2)(f). Here's the link: [Rule 5160:1-2-01 - Ohio Administrative Code | Ohio Laws](#).

I'll let you know what I find out regarding the question about enrollments by phone.

Steven Alexander
Director of Legislative Affairs
The Ohio Department of Medicaid

Ohio Department of Job and Family Services
Ohio Medicaid Estate Recovery

What is estate recovery?

Estate recovery seeks to obtain repayment for the cost of Medicaid benefits once a Medicaid recipient is deceased. This happens after the death of a Medicaid recipient who was either permanently institutionalized or age 55 and older.

What is an estate?

An estate is all of the real and personal property owned by a Medicaid recipient at the time of death, whether or not it passed through probate court.

What Medicaid benefits are subject to estate recovery?

All Medicaid payments for services received since January 1995 are subject to estate recovery. This includes Medicare premium assistance payments.

How does estate recovery work?

The estate's executor is responsible for notifying the Ohio Attorney General's Office (AGO) of a Medicaid recipient's death, if the consumer was permanently institutionalized or age 55 or older. Once the AGO has been notified, the AGO will present a claim to the estate.

Are there exceptions to estate recovery?

If there is an undue hardship to a survivor, the right to immediate recovery may be delayed or waived. Undue hardship is determined on a case-by-case basis.

When does estate recovery take place?

Recovery from the estate will only be made:

- ✓ After the death of the Medicaid recipient's surviving spouse.
- ✓ When the deceased Medicaid recipient has no surviving child younger than age 21.
- ✓ When the deceased Medicaid recipient has no surviving child of any age who is considered blind or disabled under Medicaid regulations.

Is a person's house subject to estate recovery?

Yes. A Medicaid recipient's house may be subject to estate recovery. If the recipient was permanently institutionalized, any claim from the sale of a house may be delayed while the recipient's sibling or child resides in the home, if specific conditions are met.

Does a will protect assets from estate recovery?

No. Ohio's Medicaid program and other creditors are paid before any assets are distributed to heirs or other beneficiaries.

Will the Attorney General's Office contact the family of the deceased?

After a Medicaid recipient dies, the AGO will send a notice of claim to the estate's executor requesting repayment for the cost of Medicaid benefits. It is the estate executor's responsibility to notify any family members or other heirs who might be affected by the estate recovery. If the estate executor has not been identified to the AGO, the AGO may need to contact the Medicaid recipient's family members.

How can the Attorney General's Office be reached?

The Medicaid Estate Recovery Unit of the AGO can be contacted at:

Medicaid Estate Recovery Unit
150 E. Gay Street, 21st Floor
Columbus, Ohio 43215-3130

Information is also available online at http://www.ag.state.oh.us/business/estate_recovery.asp or by calling the Ohio Medicaid Consumer Hotline at 1-800-324-8680.

I received a copy of the Ohio Medicaid Estate Recovery form (JFS 07400). I have read it or it has been read to me, and I understand it.	
Applicant Signature	Date
Authorized Representative Signature	Date
If an "X" is used, Witness Signature	Date

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The State Medicaid Manual

Publication # 45

Title The State Medicaid Manual

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State Medicaid Manual

Part 3 - Eligibility

Department of Health and
Human Services (DHHS)
HEALTH CARE FINANCING
ADMINISTRATION (HCFA)

Transmittal 75

Date: JANUARY 11, 2001

<u>HEADER SECTION NUMBERS</u>	<u>REVISED PAGES</u>	<u>REPLACED PAGES</u>
3810 - 3810 (Cont.)	3-9-3 - 3-9-9 (7 pp.)	3-9-3 - 3-9-7 (5 pp.)

NEW/REVISED MATERIAL--EFFECTIVE DATE: February 15, 2001

These instructions provide further policy clarification on mandatory and optional recovery when a Medicaid beneficiary, permanently institutionalized, any age, and age 55 or older, receives services that are specified as collectable services under the State's plan for estate recovery.

Section 3810, Medicaid Estate Recoveries.--These instructions: (1) identify the groups of dual eligibles for Medicaid estate recovery purposes; (2) explain that premium payments made to a managed care organization on behalf of a Medicaid beneficiary are collected either in whole or in part of the claim against the individual's estate; (3) identify assets and resources of Native Americans that are exempt from Medicaid estate recovery, and those that are recoverable; (4) exclude from Medicaid estate recovery government reparation payments to special populations; (5) allow States to collect against an annuity if the State uses State probate law to define estate, and the law includes annuities, or if the State uses the expanded definition of estate; and (6) defines a home of modest value.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

3810. MEDICAID ESTATE RECOVERIES

Under the estate recoveries provisions in §1917(b) of the Act, you must recover certain Medicaid benefits correctly paid on behalf of an individual. The following instructions explain the rules under which you must recover from an individual's estate Medicaid benefits correctly paid and incorrectly paid.

A. Adjustment and Recovery.--You must seek adjustment or recovery of medical assistance correctly paid on behalf of an individual under your State plan as follows.

1. Permanently Institutionalized Individuals.--All States that impose the Tax Equity Fiscal Responsibility Act (TEFRA) liens are required to determine if an individual is permanently institutionalized. TEFRA liens are pre-death liens that are placed upon the home of living beneficiaries who have been determined (after notice and opportunity for a hearing) to be permanently institutionalized. These liens must follow rules set out in the TEFRA of 1982. In the case of permanently institutionalized individuals who the State determines cannot reasonably be expected to be discharged and return home, including individuals of any age, you must seek adjustment or recovery from the individual's estate or upon sale of the property subject to a lien, at a minimum, of amounts spent by Medicaid on the person's behalf for services provided in a nursing facility, ICF/MR, or other medical institution. The date on which you determine the individual to be permanently institutionalized does not affect which expenditures you must or may recover from the individual or his/ her estate. If you elect to recover all medical assistance, it would include assistance furnished prior to the time you determined the individual to be permanently institutionalized. If you only elect to recover for expenditures for institutional services, you must recover for all institutional services furnished to the individual, regardless of whether they were furnished during the current stay in the facility. Your State plan must reflect the medical assistance subject to recovery. Recoveries must be made from the individual's estate (after death) or from the proceeds of the sale of the property on which a lien has been placed.

Permanently institutionalized individuals are persons of any age who are inpatients in a nursing facility, ICF/MR, or other medical institution as defined in 42 CFR 435.1009, and who must, as a condition of receiving services in the institution under your State plan, apply their income to the cost of care, as provided in 42 CFR 435.725, 42 CFR 435.733, 42 CFR 435.832, and 42 CFR 436.832.

If you use TEFRA liens, you must specify in your State plan the process by which you will determine that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home, the notice to be given the individual, the process by which the individual will be given the opportunity for a hearing, the hearing procedures, and by whom and on what basis the determination that the individual cannot reasonably be expected to be discharged from the institution will be made. States are not required to use the Supplemental Security Income intent to return home rule for purposes of determining whether an individual is permanently institutionalized for purposes of estate recovery. This rule applies only to eligibility determinations.

2. Individuals Age 55 or Older.--You must seek adjustment or recovery from the estate of an individual who was age 55 or older when that person received medical assistance. You must recover up to the total amount spent by Medicaid on the person's behalf, for spending on nursing facility services, (which includes skilled nursing facility and intermediate care facility for the mentally retarded services), home and community based services, as defined in §§1915(c) and (d), 1929, and 1930 of the Act, and related hospital and prescription drug services. Related hospital and

prescription drug services are any hospital care or prescription services provided to an individual while receiving nursing facility services and home and community-based services. At your option, you may also recover additional amounts up to the total amount spent on the individual's behalf for medical assistance for any or all other items or services under your State plan. List these other items and services in your State plan. Recovery is limited to medical assistance for services received at age 55 or thereafter.

3. Dual Eligibles--Dual eligibles are individuals who are entitled to Medicare Hospital Insurance under Part A and/or Supplementary Medical Insurance under Part B and are eligible for some form of Medicaid benefit. Depending on the eligibility category, Medicaid may provide benefits limited to payment of Medicare cost-sharing expenses (premiums, deductibles, and coinsurance) or only Medicare Part B premiums, and for some groups full Medicaid benefits. (See SMM sections 3489-3492 for the eligibility criteria and benefits available.)

a. Mandatory Estate Recovery--You must recover from the estate of the following dual eligibles who receive full Medicaid benefits in addition to Medicare: (1) Qualified Medicare Beneficiaries with full Medicaid benefits (QMB Plus), (2) Specified Low-Income Medicare Beneficiaries with full Medicaid benefits (SLMB Plus), and (3) Medicaid Only Dual Eligibles (non QMB, SLMB, or QDWI). You must recover from the individual's estate for the Medicaid mandatory services (nursing facility, home and community-based services, and related prescription and hospital services) as well as for optional medical assistance recovery specified in the State plan for the groups described. In addition, you must include in your claim against the estate, medical assistance amounts expended for Medicare cost-sharing and/or Medicare premiums.

b. Optional Estate Recovery--Low income Medicare beneficiaries, who are receiving assistance from Medicaid agencies in the payment of their Medicare copayments and/or deductibles, can be exempt from Medicaid estate recovery, at State option, because they are not entitled to, or receiving, any Medicaid mandatory services which are subject to recovery.

4. Individuals With Long Term Care Insurance Policies--

a. Adjustment or Recovery Required--Except as provided in §3810.A.4.b, you must seek adjustment or recovery from the individual's estate for all Medicaid costs for nursing facility and other long term care services if: (1) assets or resources are disregarded to the extent of payments made under a long term care insurance policy; or (2) assets or resources are disregarded because the individual received (or is entitled to receive) benefits under a long term care insurance policy.

b. Assets or Resources Disregarded/Not Disregarded--If you had an approved State plan, as of May 14, 1993, (California, Connecticut, Indiana, Iowa, and New York) which provided for the disregard of assets or resources in determining eligibility for medical assistance either to the extent that payments are made under a long term care insurance policy, or because an individual has received or is entitled to receive benefits under such a policy, you are not required to seek adjustment or recovery from the individual's estate for Medicaid costs for nursing facility and other Medicaid long term care expenses. While HCFA cannot compel you to recover any amounts from the estates of these individuals, you are free to do so if consistent with the terms of your State plan.

5. Adjustment or Recovery Limitations.--Adjustment or recovery can only be made after the death of the individual's surviving spouse, if any, and only at a time when the individual has no surviving child under age 21, or a blind or disabled child as defined in §1614 of the Act. For Guam, Puerto Rico, and the Virgin Islands, any surviving child's blindness or permanent or total disability would be determined under the definitions found in the State plan program for providing assistance to the blind or permanently and totally disabled. If a lien is placed on an individual's home, adjustment or recovery can only be made when: (1) there is no sibling of the individual residing in the home, who has resided there for at least one year immediately before the date of the individual's admission to the institution, and has resided there on a continuous basis since that time; and (2) there is no son or daughter of the individual residing in the home, who has resided there for at least two years immediately before the date of the individual's admission to the institution, has resided there on a continuous basis since that time, and can establish to the agency's satisfaction that he/she has been providing care which permitted the individual to reside at home rather than in an institution.

6. Estate Recovery and Managed Care.--When a Medicaid beneficiary, permanently institutionalized, or age 55 or older, is enrolled (either voluntarily or mandatorily) in a managed care organization and services are provided by the managed care organization that are included under the State's plan for estate recovery, you must seek adjustment or recovery from the individual's estate for the premium payments in your claim against the estate. When the beneficiary enrolls in the managed care organization, you must provide a separate notice to the beneficiary that explains that the premium payments made to the managed care organization are included either in whole or in part in the claim against the estate.

I find NO Notice. I Also Feel THEY Should State The Amount Each Month.

o If you have elected in your State plan amendment to recover for all Medicaid services, then you must recover from the individual's estate the total capitation rate for the period the beneficiary was enrolled in the managed care organization.

o If you have elected in your State plan amendment to recover for some services covered under the State plan, but not all services, then you must recover from the individual's estate that portion of the capitation payment that is attributable to the recoverable services, based on the most appropriate actuarial analysis determined by the State.

7. American Indians and Alaska Natives.--The Federal government has a unique trust responsibility for American Indian (AI) Tribes and Alaska Native (AN) Villages and their members. Section 1917(b)(3) of the Social Security Act gives the Secretary authority to establish standards for hardship. This includes exemptions from estate recovery for certain assets and resources.

a. American Indians and Alaska Natives: Income, Resources and Property Exempt from Medicaid Estate Recovery.--The following AI/AN income, resources, and property are exempt from Medicaid estate recovery:

1. Certain AI/AN income and resources (such as interests in and income derived from Tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) that are exempt from Medicaid estate recovery by other laws and regulations;

2. Ownership interest in trust or non-trust property, including real property and improvements:

Ohio Administrative Code

Rule 5160:1-2-01 Medicaid: administrative agency responsibilities.

Effective: December 14, 2020

(A) This rule describes the responsibilities of the administrative agency.

(B) Calculation of time periods for eligibility determinations. All calculations of time periods used in the determination of eligibility, including an annual renewal or a redetermination as a result of a reported change, shall be computed as follows:

(1) When counting the number of days in a specified time period, the initial day is excluded from the computation and the last day is included.

(2) When the last day of the time period falls on a Saturday, Sunday, or legal holiday, the time period shall end on the next business day.

(C) Effective date of applications, reported information, or requests for applications or assistance. Applications, documents, or information submitted or provided to the administrative agency, or requests made to the administrative agency, are considered received by the administrative agency:

(1) That day, when received by the administrative agency or the electronic eligibility system during the administrative agency's business hours.

(2) On the next business day, when received by the administrative agency or the electronic eligibility system after the administrative agency's business hours or on a non-business day when the administrative agency is closed.

(D) Request for application. When an individual requests an application, the administrative agency shall:

(1) Not deny an individual's right to apply or discourage an individual from applying.

(2) Inform the individual of the following:

(a) An online application portal is available to complete an application for medical assistance and application assistance is available through the portal.

(b) The beginning date of benefits depends on the date the signed application is received by the administrative agency.

(c) The verification requirements and deadlines.

(d) Individuals shall cooperate with eligibility determinations, renewals, redeterminations, audits, and quality control processes as defined in this chapter of the Administrative Code.

(e) The meaning of and penalties for medicaid eligibility fraud as set forth in section 2913.401 of the Revised Code.

(f) The Ohio attorney general (AGO) shall seek recovery or adjustment on behalf of the administrative agency from the estate of the following individuals, as set forth in rule 5160:1-2-07 of the Administrative Code:

(i) A permanently institutionalized individual of any age; or

(ii) An individual fifty-five years of age or older who is not permanently institutionalized.

(3) Fulfill a request for an application within one business day.

(a) Fulfillment occurs when the administrative agency sends an electronic copy of the application or a link to an electronic copy of the application to the text or email address provided by the individual; hands the application to the individual; or places the application in the U.S. mail. When the application is provided in person or via U.S. mail, the administrative agency shall enclose a preaddressed, postage-paid envelope for return of the application.

(b) The application shall be accompanied by the JFS 07217 "Voter Registration Notice of Rights and

The affordable care act conflicts with Ohio Medicaid

Dec 10, 2020

18262 2 AB 0.419T98 **AUTOALL FOR AADC 430 PL6 R



(services?)

Application Date: December 10, 2020

2021 Application ID:

Eligibility notice: You may be eligible for free or low-cost coverage through Medicaid or the Children's Health Insurance Program (CHIP)

Household member(s)	Results	Next steps
	<ul style="list-style-type: none"> May be eligible for free or low-cost coverage through Ohio Medicaid. This result is based on the monthly household income of \$1,368.28 that you provided on your Marketplace application. 	<ul style="list-style-type: none"> You'll get a final decision from the Ohio Department of Medicaid.

If your "Results" say you're eligible for advance payments of the premium tax credit or cost-sharing reductions, it means that you don't appear to be eligible for Medicaid based on your application information. However, you could still be eligible for Medicaid if you have a disability or special health care needs that you didn't report on your application. To learn more, visit [HealthCare.gov/people-with-disabilities](https://www.healthcare.gov/people-with-disabilities) or call your state Medicaid agency to ask about rules for your state.

What should I do next?

Here's what each person in your household needs to do to take the "Next steps" shown in this notice. If your "Next steps" tell you to send more information, follow instructions for sending it. If you don't, you could lose what you qualify for now because your information doesn't match the data we have, or we can't verify all of the information in your application.

If your "Results" say that you or any of your family members are or may be eligible for free or low-cost coverage through Ohio Medicaid or Ohio Medicaid, you'll get a notice from your state agency with more

? ?

information about your health benefits and how much you pay for them. If you don't hear from them soon, call them at the phone number provided at the end of this notice. When you're eligible for Medicaid or CHIP, you can still buy a Marketplace health plan, but you won't get help paying for it. Medicaid and CHIP are free or low-cost programs, so if you qualify for either of them, you don't qualify for advance payments of the premium tax credit.

What if information from my application changes during the year?

If you have life changes and the information you gave us when you applied is no longer correct, you need to let us know within 30 days of the change. Changes may affect your eligibility for:

- Premium tax credits
- Cost-sharing reductions that lower your copayments, coinsurance, and deductibles
- Coverage through Ohio Medicaid or Ohio Medicaid

If you enroll in a Marketplace plan and later become eligible for other qualifying coverage, like Medicaid, CHIP, Medicare, or coverage through a job, you won't be eligible for advance payments of the premium tax credit, although you can keep your Marketplace plan and pay the full premium. If you become eligible for other qualifying coverage, you must contact the Marketplace to end your advance payments of the premium tax credit and let the Marketplace know if you also want to end your health plan. If you don't stop the advance payments of your premium tax credit to your health insurance company, you may need to pay back the payments paid on your behalf.

If someone works for a business that offers help paying for a health plan or health care expenses through a Health Reimbursement Arrangement (HRA), visit HealthCare.gov/job-based-help to learn how this may affect your eligibility for the premium tax credit.

What should I do if I think my "Results" are wrong?

If you think we made a mistake, you can appeal a final determination of eligibility to the Marketplace Appeals Center. This includes your eligibility to buy health coverage through the Marketplace, for premium tax credits, cost-sharing reductions, and enrollment periods. See below for more information about appealing your eligibility for Ohio Medicaid or Ohio Medicaid. Please note that:

- If you need health services right away and a delay could seriously jeopardize your health, you can ask for a fast (expedited) appeal using the Appeal Request form or by sending a fax or a letter to the address below.
- You can represent yourself or appoint a representative to help you with your appeal. This person can be a friend, relative, lawyer, or someone else.
- You can ask to keep your eligibility during your appeal. If you were previously eligible for Marketplace coverage or financial assistance and your eligibility is changed, you can appeal this change. In this case, you may be able to keep your previous eligibility during your appeal.
- The outcome of an appeal could change the eligibility of other members of your household even if they don't ask for an appeal.

How much time do I have to request an appeal?

Generally, you have 90 days from the date of your eligibility notice to request an appeal. However, if this



notice says that someone needs to submit documents, then you must follow instructions for sending them. Until you submit documents and your issue is resolved, your eligibility notice isn't a final determination of eligibility and it can't be appealed.

How do I request an appeal?

- **Online:** Visit [HealthCare.gov/marketplace-appeals/appeal-forms](https://www.healthcare.gov/marketplace-appeals/appeal-forms) and select your state. You can submit your appeal request online or download/print a form and submit it separately.
- **By mail or fax:** Send a completed paper form or a letter requesting an appeal. Include your name, address, and the reason for the appeal. If the appeal is for someone else (like your child), also include their name. Submit your paper form or the letter to the Marketplace:

Fax: 1-877-369-0130

Mail: Health Insurance Marketplace

ATTN: Appeals

465 Industrial Blvd.

London, KY 40750-0061

Appealing your eligibility for Medicaid or CHIP

If this notice says that you may be eligible for Medicaid or CHIP, or that your state is reviewing your eligibility for Medicaid or CHIP, your state Medicaid or CHIP agency will send a notice to let you know if you qualify for these free or low-cost programs.

If your state determines that you're not eligible for Medicaid or CHIP:

- Your state will tell you how to ask for a Medicaid fair hearing through the state fair hearing process.
- You may also be able to resubmit your Marketplace application for health coverage through the Marketplace and help with costs. If you then disagree with your updated "Results," you can request an appeal through the Marketplace Appeals Center.

For more information about your Medicaid or CHIP eligibility, including your right to appeal if your state determines you're not eligible for Medicaid or CHIP, contact your state Medicaid or CHIP agency at the phone number included at the end of this notice.

For more help

- Visit [HealthCare.gov](https://www.healthcare.gov) or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325. You can also make an appointment with an assister who can help you. Information is available at [LocalHelp.HealthCare.gov](https://www.localhelp.healthcare.gov).
- Contact your state's Medicaid agency toll-free: 1-800-345-8680 (TTY: 800-324-8680) for information about Ohio Medicaid. For more information about Ohio Medicaid, contact the Ohio Department of Medicaid toll-free: 1-800-324-8680 (TTY: 1-800-292-3572).
- Get help in a language other than English. Information about how to access these services is included with this notice, and available through the Marketplace Call Center.
- Call the Marketplace Call Center to get this information in an accessible format, like large print, Braille, or audio, at no cost to you.

For information including more about advance payments of the premium tax credit, lower out-of-pocket costs,

and Medicaid eligibility, visit HealthCare.gov.

Sincerely,

Health Insurance Marketplace
Department of Health and Human Services
465 Industrial Boulevard
London, Kentucky 40750-0001

The determinations or assessments in this letter were made based upon 45 CFR 155.305, 155.410, 155.420-430 and 42 CFR 435.603, 435.403, 435.406 and 435.911.

Privacy Disclosure: The Health Insurance Marketplace protects the privacy and security of the personally identifiable information (PII) that you have provided (see HealthCare.gov/privacy/). This notice was generated by the Marketplace based on 45 CFR 155.230 and other provisions of 45 CFR part 155, subpart D. The PII used to create this notice was collected from information you provided to the Health Insurance Marketplace. The Marketplace may have used data from other federal or state agencies or a consumer reporting agency to determine eligibility for the individuals on your application. If you have questions about this data, contact the Marketplace at 1-800-318-2596 (TTY: 1-855-889-4325).

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1207.

Nondiscrimination: The Health Insurance Marketplace doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age. If you think you've been discriminated against or treated unfairly for any of these reasons, you can file a complaint with the Department of Health and Human Services, Office for Civil Rights by calling 1-800-368-1019 (TTY: 1-800-537-7697), visiting hhs.gov/ocr/civilrights/complaints, or writing to the Office for Civil Rights/ U.S. Department of Health and Human Services/ 200 Independence Avenue, SW/ Room 509F, HHH Building/ Washington, D.C. 20201.

Why do those 55 and over have a payback when
those under the age of 55 don't!?
Sounds like age discrimination to me.

006002-043977-001-02-003-0018262



Understanding Your Eligibility Notice

Am I eligible for coverage?	<p>Your eligibility notice tells you which people on your application qualify to get health coverage through the Health Insurance Marketplace, Medicaid, or the Children's Health Insurance Program (CHIP).</p> <p>Medicaid and CHIP provide free or low-cost coverage to people with limited income, disabilities, and in some other situations. Almost anyone can enroll in Marketplace coverage, but you can only enroll at certain times.</p>
What to do next	<p>Look at the table that starts on page 1 of your notice. Each person listed on your application needs to follow instructions in the "Next steps" column.</p>
Medicaid & CHIP	<p>People who have health coverage through Medicaid or CHIP will pay little or nothing for health services and probably don't need a Marketplace plan.</p> <p>If your notice says that you or your family members are eligible for Medicaid or CHIP, you'll get a notice from your state agency telling you about these programs.</p>
What if I miss a deadline?	<p>If you miss a deadline in your notice to submit information or enroll in a plan, you may not be able to enroll in a Marketplace plan until the next yearly Open Enrollment Period, for coverage starting January 1 of the next year.</p>
Paying my premium	<p>You'll pay your premium directly to your health plan, not the Marketplace. Your plan will send you information on when and how to pay. If you don't hear from your health plan, you should call or visit their website. For more about paying your premium, visit HealthCare.gov/apply-and-enroll/complete-your-enrollment.</p>

Special Enrollment Periods

If your notice says you qualify for a Special Enrollment Period, this means you have a chance to enroll in Marketplace coverage outside the Open Enrollment Period. You may qualify for a Special Enrollment Period if you've had a life event like losing health coverage, moving, getting married, having a baby, adopting a child, or being newly offered an individual coverage HRA or newly provided a QSEHRA. For some Special Enrollment Periods, you may need to submit documents to confirm your eligibility, and your plan choices may be limited.

If you qualify for a Special Enrollment Period, you usually have up to 60 days after the life event to enroll in a plan. If you miss that window, you may have to wait until the next Open Enrollment Period to enroll or until you have another qualifying life event.

You should re-apply for Marketplace coverage every year

Even if you're already enrolled, you should re-apply for Marketplace coverage every year to make sure your information is up-to-date. If you chose to let the Marketplace use tax information to help with your re-enrollment, your information updates automatically.

If you have Medicaid, you'll get a letter from your state agency if you need to provide more information at re-enrollment time.

If you have an individual coverage HRA, be sure to update your Marketplace application when the HRA plan year ends. This might occur before the Marketplace Open Enrollment period, when you'll re-apply for Marketplace coverage.

Why do I need to report my income?

You don't have to report your income to get Marketplace coverage, but if you do, the Marketplace will check to see if you qualify for tax credits, cost-sharing, or other programs that could lower your costs.

Bronze, Silver, Gold & Platinum categories

Health plans sold in the Marketplace are divided into 4 categories: Bronze, Silver, Gold, and Platinum. They range from Bronze plans with lower premiums and higher out-of-pocket costs, to Platinum plans with higher premiums and lower out-of-pocket costs. Plan choices may be limited during a Special Enrollment Period.

All plans cover all essential health benefits, and there are no dollar limits on the care you can get.

Catastrophic plans

A "Catastrophic" plan is a plan with lower monthly premiums that mainly protects you from very high medical costs. People under age 30 and people with hardship exemptions can buy a Catastrophic plan through the Marketplace. These plans aren't eligible for premium tax credits.

08009-043977-401-02-003-0018202



 Tom Jones Insurance_Online Contact Us

Name Lisa Johnson

Phone Number

Email imlisajohnson@outlook.com

Message

Hi Bob, . suggested I get in touch with you. I am ready to storm the White House! My dad died July 4th - suddenly. At only 64 years old. As a poor man, he thought was receiving completely free healthcare by signing up with CareSource. It has now come back to me with a bill for \$70,000 against his estate. I would love to chat with you about how I can help; I've been researching the legislation you've pushed - for at least, consumer acknowledgement. I can't believe OH doesn't even have to tell people they can come after your estate after you die. The more I read, the sicker I am. I want this to be completely abolished. It's fraud, it's a scam, it's diabolical. So...if you want to chat, I would love to! I live in Italy so we'll need to Zoom or converse via email or WhatsApp. Let me know if you're interested in joining forces.



Office of the Ohio Attorney General
Collections Enforcement Section

Collections Enforcement-
Stanley R. Evans, Special Counsel
Elsass, Wallace, Evans & Co., L.P.A.
100 South Main Avenue, Ste. 102
P.O. Box 499
Sidney, OH 45365-0499
Telephone: (937) 492-6191
Fax: (937) 492-0876

September 8, 2022

David L. Mikel, Esq.
111 South Plum Street
Troy, OH 45373

Re: **Jim A. Johnson, Deceased**
Medicaid Account #19506240/MIA
Miami County Probate Court, Case No. 92778

Dear Attorney Mikel:

The undersigned has been appointed Special Counsel to the Ohio Attorney General. The above-referenced claim has been assigned to me, as Special Counsel, for further action and collection. Please be advised that the Ohio Department of Medicaid (the "Department") hereby presents the enclosed interim claim against the above-referenced decedent. The amount of the interim claim is SIXTY-NINE THOUSAND EIGHT HUNDRED THREE AND 61/100 DOLLARS (\$69,803.61). This claim is for Medicaid payments made on behalf of the decedent and is made pursuant to 42 U.S.C. Section 1396p(b) and Ohio Revised Code Section 5162.21.

Please note that the Department cannot provide a final claim amount until 6 months from a deceased recipient's date of death, as providers have 6 months from a recipient's death to submit bills to Medicaid for payment. Accordingly, the Department's claim may increase as additional bills are paid during this time period. As such, we will request a detail report after January 4, 2023, and advise what the Department's final claim amount will be upon receipt of the requested detail report.

A request for an undue hardship waiver may be made within thirty calendar days from the date on which this claim was mailed. Please note that O.A.C. 5160:1-2-07 defines undue hardship and sets forth the process for requesting an undue hardship waiver.

Please contact the undersigned with any questions regarding this claim. Any unresolved issues can be presented to the Probate Court for resolution.

Thank you for your assistance in this matter.

Very truly yours,


Stanley R. Evans, Special Counsel

Date Mailed: Sept 9, 2022
sre:drl
Enclosure: Claim, Copy of Fiduciary Letter

S:\Denna\Medicaid\2022\Johnson, Jim Attorney Claim Ltr need to wait 6 mons.doc



DAVE YOST
OHIO ATTORNEY GENERAL

Collections Enforcement
Office 614-466-8360
Fax 614-752-9070

July 27, 2022

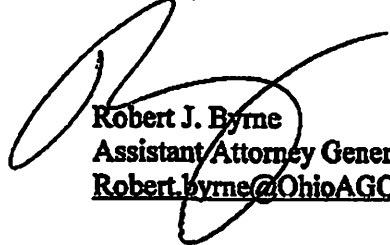
David Mikel
111 S Plum Street
Troy, Ohio 45373

RE: Jim Johnson, #910000818952

Dear Counselor:

Enclosed please find a printout of bills paid by Medicaid on behalf of the decedent. The claim total is \$69,729.10. Should you have any questions, please call me at (614) 752-8085. Thank you for your assistance in this matter.

Sincerely,



Robert J. Byrne
Assistant Attorney General
Robert.byrne@OhioAGO.gov

Report : TPL-0030-R
 Process : TPLJR030
 Location: TPL0030R

MITS
 Medicaid Information Technology System
 ESTATE RECOVERY - RECIPIENT DETAIL REPORT
 REPORT PERIOD: 07/26/2022

Run Date: 07/26/2022
 Run Time: 19:18:08
 Page: 1

RECIPIENT NAME: JOHNSON, JIM

RECIPIENT ID NUMBER: 910000818952 ESTATE RECOVERY: 2144492 TRACKING START DATE: 10/28/2012

CLAIM TYPE	DATE(S) OF SERVICE	PROVIDER NAME	PROVIDER NUMBER	DATE PAID	AMOUNT PAID
N/A	N/A	N/A	N/A	N/A	N/A

TOTAL NUMBER OF CLAIMS: 0 TOTAL AMOUNT PAID: \$0.00

SUMMARY OF PAYMENTS:

CLAIM TYPE	NUMBER OF CLAIMS	AMOUNT PAID	CLAIM TYPE DESCRIPTION
N/A	N/A	N/A	N/A
TOTALS:	0	\$0.00	

BUYIN PREMIUM PAYMENTS:

MONTH	PART A PREMIUM PAID	PART B PREMIUM PAID	TOTAL
N/A	N/A	N/A	N/A

SUMMARY OF PAYMENTS 90.00

Report : TPL-0030-R
Process : TPLJRO30
Location: TPL0030R

MITS
Medicaid Information Technology System
ESTATE RECOVERY - RECIPIENT DETAIL REPORT
REPORT PERIOD: 07/26/2022

Run Date: 07/26/2022
Run Time: 19:16:08
Page: 2

RECIPIENT NAME: JOHNSON, JIM

RECIPIENT ID NUMBER: 910000818952 ESTATE RECOVERY: 2144492 TRACKING START DATE: 10/28/2012

MANAGED CARE PREMIUM PAYMENTS:

MONTH	TOTAL
01/2017	\$917.54
02/2017	\$917.54
03/2017	\$917.54
04/2017	\$917.54
05/2017	\$917.54
06/2017	\$917.54
07/2017	\$885.52
08/2017	\$885.52
09/2017	\$885.52
10/2017	\$885.52
11/2017	\$885.52
12/2017	\$885.52
01/2018	\$900.41
02/2018	\$900.41
03/2018	\$900.41
04/2018	\$900.41
05/2018	\$900.41
06/2018	\$900.41
07/2018	\$933.89
08/2018	\$933.89
09/2018	\$933.89
10/2018	\$933.89
11/2018	\$933.89
12/2018	\$933.89
01/2019	\$892.36
02/2019	\$892.36
03/2019	\$892.36
04/2019	\$892.36
05/2019	\$892.36

Report : TPL-0030-R
Process : TPLJRO30
Location: TPL0030R

MITS
Medicaid Information Technology System
ESTATE RECOVERY - RECIPIENT DETAIL REPORT
REPORT PERIOD: 07/26/2022

Run Date: 07/26/2022
Run Time: 19:18:08
Page: 3

RECIPIENT NAME: JOHNSON, JIM

RECIPIENT ID NUMBER: 910000818952 ESTATE RECOVERY: 2144492 TRACKING START DATE: 10/28/2012

06/2019	5892.36
07/2019	9953.51
08/2019	9954.45
09/2019	9954.45
10/2019	9954.45
11/2019	9954.45
12/2019	9954.45
01/2020	\$1,220.23
02/2020	\$1,220.23
03/2020	\$1,220.23
04/2020	\$1,220.23
05/2020	\$1,220.23
06/2020	\$1,220.23
07/2020	\$1,147.78
08/2020	\$1,147.78
09/2020	\$1,147.78
10/2020	\$1,147.78
11/2020	\$1,147.78
12/2020	\$1,147.78
01/2021	\$1,176.03
02/2021	\$1,176.03
03/2021	\$1,176.03
04/2021	\$1,176.03
05/2021	\$1,176.03
06/2021	\$1,176.03
07/2021	\$1,176.03
08/2021	\$1,176.03
09/2021	\$1,170.07
10/2021	\$1,170.07
11/2021	\$1,170.07
12/2021	\$1,170.07
01/2022	\$1,211.62
02/2022	\$1,211.62

Report : TPL-0030-R
Process : TPLJR030
Location: TPL0030R

MITS
Medicaid Information Technology System
ESTATE RECOVERY - RECIPIENT DETAIL REPORT
REPORT PERIOD: 07/26/2022

Run Date: 07/26/2022
Run Time: 19:38:08
Page: 4

RECIPIENT NAME: JOHNSON, JIM

RECIPIENT ID NUMBER: 910000818952 ESTATE RECOVERY: 2144492 TRACKING START DATE: 10/28/2012

03/2022	\$1,211.62
04/2022	\$1,211.62
05/2022	\$1,211.62
06/2022	\$1,211.62
07/2022	\$1,258.72
-----	-----

SUMMARY OF PAYMENTS \$69,729.10

LONG TERM CARE PARTNERSHIP PROGRAM PAYMENTS:

NORTH	TOTAL
-----	-----
N/A	N/A
-----	-----

SUMMARY OF PAYMENTS \$0.00

END OF RECIPIENT

SMDL #14-001
ACA #29

February 21, 2014

RE: Application of Liens, Adjustments and Recoveries, Transfer-of-Asset Rules and Post-Eligibility Income Rules to MAGI Individuals

Dear State Medicaid Director:

SEE PAGE 3

This letter provides guidance to states on how the long-term services and supports-related rules, including the estate recovery rules, in section 1917 of the Social Security Act (the Act), and federal regulations at 42 C.F.R. 435.700, et seq., apply to individuals who are eligible for Medicaid under Modified Adjusted Gross Income (MAGI) eligibility rules (“MAGI individuals”) and receive coverage for long-term services and supports (LTSS). The vast majority of people in need of Medicaid-covered LTSS will qualify under eligibility categories related to age or disability. The MAGI rules do not apply to these categories, and states generally are not required to offer LTSS in the Alternative Benefit Plans (ABPs) that are available to MAGI individuals. However, some people who need LTSS may qualify for Medicaid under MAGI rules. In particular, MAGI individuals who are medically frail or otherwise meet one of the benefit plan exceptions listed in 42 C.F.R. 440.315 must be offered the option of a benefit plan that includes Medicaid state plan services. For most adult beneficiaries receiving state plan services, medically necessary nursing facility and home health services must be covered. Additionally, some states have chosen to include LTSS in their ABPs.

Section 1902(e)(14) of the Act directs that individuals whose Medicaid eligibility is determined using MAGI rules are not subject to an assets or resources test for purposes of determining Medicaid eligibility. However, a number of other statutory provisions are implicated when an individual seeks Medicaid coverage for LTSS. These provisions do not affect eligibility for Medicaid and they are not limited in their application based on the category under which a Medicaid LTSS applicant is eligible or the methodology applied to determine an applicant’s eligibility. States have inquired as to whether the various Medicaid LTSS rules, including the estate recovery rules, will apply to MAGI individuals who are eligible for LTSS coverage. This guidance is intended to address these questions.¹

¹ This letter does not change rules and policies expressed in existing guidance relevant to the application of section 1917’s rules to non-MAGI individuals.

A. Section 1917 of the Act (“Liens, Adjustments and Recoveries, and Transfers of Assets”)

Under section 1902(a)(18) of the Act, a state must comply with the provisions of section 1917. Section 1917, which is a long-standing provision that preceded enactment of the Affordable Care Act, contains several provisions that apply specifically in circumstances in which Medicaid applicants and beneficiaries seek LTSS coverage. The provision governs a state’s authority and responsibility to seek recovery of LTSS expenditures from Medicaid LTSS beneficiaries or their estates, and prohibits LTSS coverage where individuals have engaged in certain financial transactions before seeking LTSS coverage or have interests in certain assets.

With some exceptions, described below, application of section 1917 is not limited based on the eligibility categories in which Medicaid beneficiaries who seek LTSS coverage are enrolled or the methodologies applied to determine their eligibility. As such, most of the rules of section 1917 will apply to MAGI individuals who request Medicaid coverage for LTSS.

1. Section 1917(a): Medicaid Liens

Section 1917(a)(1)(B) permits states to place liens, subject to certain exceptions, on real property owned by a Medicaid beneficiary who is an inpatient of a nursing facility, intermediate care facility for the developmentally disabled, or other medical institutions, where the individual is receiving Medicaid coverage for the institutional services where certain other conditions apply.

One of the other conditions is that the Medicaid beneficiary has to be required, as a condition of receiving services in the institution, to spend for costs of medical care all but a minimal amount of his or her income for personal needs. The rules for “post-eligibility treatment of income” (PETI) are contained in 42 C.F.R. 435.700 et seq., which identify discrete categories of individuals who are subject to the PETI rules. MAGI individuals are not described in these provisions, and as such, these rules may not be applied to MAGI individuals under the current regulations. As a result, MAGI individuals who receive coverage for LTSS may not have liens placed on their real property at this time (see below for a broader discussion regarding the PETI rules).

2. Section 1917(b): Estate Recovery

Under section 1917(b)(1)(A), states are required to seek recovery, for Medicaid beneficiaries whose real property may be subject to a lien authorized under section 1917(a)(1)(B), from the estates of such individuals for amounts equal to the medical assistance correctly paid on their behalf. Under section 1917(b)(1)(B), states must also seek recovery, for Medicaid beneficiaries who were 55 years old and older when they received medical assistance, from the estates of such individuals for amounts at least equal to medical assistance paid on their behalf for nursing facility services, home and community based services (HCBS), and related hospital and prescription drug services, or, at state option, for any other items and services under the state plan (with the exception of Medicare cost-sharing).

For the first group—those whose real property may be subject to a lien—the prior application of the post-eligibility income rules under 42 C.F.R. 700 et seq. is a contingency, as the group in section (b)(1)(A) is made up exclusively of individuals who are described in the lien provision of 1917(a)(1)(B). Therefore, a state may not recover from the estates of MAGI individuals under this authority.

For the second group—those who were 55 years old or older when they received medical assistance and are described in 1917(b)(1)(B)—the rule is not limited in its application to individuals who were subject to post-eligibility income rules, or to individuals who received services to which the post-eligibility income rules apply (i.e., institutional services and HCBS). MAGI individuals who were 55 years old or older when they received medical assistance are therefore not exempt from the estate recovery provision in section 1917(b)(1)(B), although all of the estate recovery limitations and exceptions described in other parts of section 1917(b), including those described in section 1917(b)(2), and the exception in situations of undue hardship described in section 1917(b)(3)(A), apply.

Due to the potential barrier to enrollment that future estate recovery may create for some individuals, CMS intends to thoroughly explore options and to use any available authorities to eliminate recovery of Medicaid benefits consisting of items or services other than long term care and related services in the case of individuals who are determined eligible for Medicaid benefits using the MAGI methodology. *AS OF THIS DATE NOTHING DONE!*

In the meantime, states have some existing authority to limit the scope of recovery for Medicaid beneficiaries. They may limit recovery based on the eligibility categories in which the beneficiaries are enrolled; for example, a state may limit estate recovery to the services under section 1917(b)(1)(B)(i) for people enrolled in the new adult group – that is those relating to LTSS. Furthermore, in view of the federal government's unique trust responsibility for the American Indian/Alaska Native (AI/AN) population, the State Medicaid Manual provides specific exemptions from estate recovery that are applicable to this population. In addition to complying with these manual provisions, states may also want to take into consideration other situations in which estate recovery would present undue hardship to the AI/AN population when establishing exemptions as permitted in section 1917(b)(3)(A) and noted above.

3. Section 1917(c): Transfers of Assets

Section 1917(c) prescribes certain rules where individuals who are seeking Medicaid coverage for LTSS have transferred assets for less than fair market value before, and subsequent to, applying for Medicaid. Specifically, this provision requires that, if an institutionalized individual, or the spouse of an institutionalized individual (or, at state option, a non-institutionalized individual or the spouse of a non-institutionalized individual) disposes of assets for less than fair market value on or after the individual's "look-back" date, the individual is ineligible for medical assistance for institutional services (or other LTSS). A penalty period based on the number of months equal to the amount transferred for less than fair market value divided by the average monthly cost to a private patient of nursing facility services in the state is applied. Exceptions, such as where an individual makes a transfer to a spouse or for a purpose other than to qualify for Medicaid, do apply. In the absence of an exception, however, the penalty period applies.

An “institutionalized individual” is defined in section 1917(h)(3) to include an inpatient of a nursing facility or other medical facility in which payment is being made based on the level-of-care provided in a nursing facility, and an individual receiving any service under section 1915(c) who is eligible under section 1902(a)(10)(A)(ii)(VI). The latter group, sometimes referred to as the “217” group (after the group’s corresponding regulatory cite, 42 C.F.R. §435.217), is composed of individuals who are only eligible for Medicaid based on the application of institutional deeming rules (and who meet the level of care necessary for a HCBS waiver and are receiving at least one waiver service).

Non-institutionalized individuals are defined in section 1917(h)(4) to include recipients of personal care services, home health services, and, at state option, other non-institutional LTSS services available under the state plan to individuals who need LTSS. The word “assets” is defined in section 1917(h)(1) to include all income and resources of the individual and the individual’s spouse, including any income or resources which the individual or individual’s spouse is entitled to but does not receive because of action by the individual, the individual’s spouse, or others acting on their behalf.

As noted above, section 1902(e)(14) provides that individuals whose Medicaid eligibility is determined using MAGI rules may not have any “any assets or resources test” applied for purposes of determining Medicaid eligibility. The directive applies only to Medicaid *eligibility* determinations for MAGI individuals. By contrast, section 1917(c) applies to *coverage* for certain services—nursing facility services and other LTSS—in circumstances where Medicaid applicants have transferred assets for less than fair market value. Considering this, and the fact that, outside of the reference to the 217 group in the definition of institutionalized individuals, the application of the transfer rules in section 1917(c) is not limited by the eligibility category in which a Medicaid beneficiary is enrolled or the methodology by which the individual’s eligibility is determined, we have concluded that the transfer rules should apply to MAGI individuals who meet the definition of “institutionalized individuals,” and to “non-institutionalized individuals” in states that have opted to apply the transfer rules to non-institutionalized individuals.

This provision applies only to individuals who receive Medicaid funding for LTSS. All of the limitations and exceptions to the transfer rules described in section 1917(c)(2) would apply.

4. Other Provisions of section 1917

Section 1917 contains several other rules that are relevant in the context of coverage for LTSS.

Annuities, promissory notes, and life estate interests

Like the broader rules of section 1917(c), the rules imposed to these transactions are generally not limited to individuals who qualify under particular eligibility categories or have their eligibility determined under a particular methodology. Therefore, states should apply the rules relating to these transactions to MAGI individuals in the same way the rules are applied to non-MAGI individuals.

Trusts

Section 1917(d) outlines the Medicaid rules for evaluating trusts that are established with the assets of a Medicaid applicant or beneficiary. Generally, a revocable trust funded by a Medicaid applicant's or beneficiary's assets is considered an available resource to the individual, while irrevocable trusts are considered asset transfers that require determinations of whether fair market value was received in exchange. Certain trusts that meet specific criteria in section 1917(d)(4) (e.g., special needs trusts and pooled trusts) are generally exempt from these standard rules, even if irrevocable, and are instead generally evaluated under cash assistance program rules (e.g., SSI rules), although these trusts are not in all circumstances exempt from the transfer rules.

The trust rules are not limited in their application to the eligibility categories under which Medicaid applicants are eligible or the methodologies used to determine their eligibility. Thus, states will have to confirm whether a MAGI individual who requests coverage for LTSS established a trust using his or her assets on or after the individual's look-back date, and evaluate such trusts under existing rules. As with non-MAGI individuals, under section 1917(d)(5), states must also waive application of the trust rules for MAGI individuals where the application of the rules will result in an undue hardship.

Home Equity Rule

Section 1917(f) provides that, in determining eligibility for medical assistance for nursing facility services or other LTSS, the individual may not be eligible for such assistance if the individual's home equity exceeds, for 2014, \$543,000, or, at state option, \$814,000 (i.e., the state's home equity limit cannot be lower than \$543,000, but it may be as high as \$814,000). Section 1917(f) directs that the figures be increased from year to year based on the percentage increase in the consumer price index for all urban consumers.

Under section 1917(f)(2), the home equity-related limitation on medical assistance for nursing facility services and other LTSS does not apply if the spouse of the individual, or a child of the individual who is under the age of 21 or has a disability, is living in the home. Under section 1917(f)(4), the limitation is also waived in cases of demonstrated hardship.

The home equity rule is not limited in its application by the eligibility category in which an individual is enrolled or the methodology on which the individual's eligibility is based. Therefore, states must deny LTSS coverage to MAGI individuals whose home equity exceeds the limit identified in the Medicaid state plan, subject to the exceptions identified in section 1917(f).

B. Post-Eligibility Treatment of Income

A state Medicaid agency is required to reduce its costs using available beneficiary income for coverage of institutional services and home and community-based waiver services provided to most Medicaid beneficiaries. The state's costs are reduced generally by the amount of available income the institutionalized Medicaid beneficiary or waiver enrollee has after deductions for the

personal needs of the individual, the maintenance needs of the individual's spouse or family, and certain other expenses are made. The process by which the individual's available income is calculated is referred to as the post-eligibility treatment of income (PETI).

Section 1902(a)(17) of the Act is the general authority for the post-eligibility income calculation process. The specific method of the calculation is established in 42 C.F.R. 435.700, et seq., for categorically needy Medicaid enrollees, and 435.832 for medically needy individuals. Regarding categorically needy Medicaid enrollees, 42 C.F.R. 435.725 (for SSI states) and 435.733 (for 209(b) states) identify the specific categories to which the post-eligibility rules apply. These categories all apply the financial methodologies of the SSI and AFDC cash assistance programs to determine eligibility for Medicaid beneficiaries enrolled in them.

Because of the connection in the post-eligibility regulations between the cash assistance programs and the discrete categories to which the regulations direct their application, we have concluded that the scope of the current post-eligibility regulations does not capture Medicaid beneficiaries whose eligibility is based on MAGI methodologies. We believe, however, that the statute provides us the authority to expand the reach of the post-eligibility regulations to include MAGI individuals who receive coverage for LTSS, and because there are equity reasons to consider the application of these rules to the MAGI-eligible people receiving LTSS, we are considering rulemaking in this case.

We intend to work closely with states to conform their rules and procedures in accordance with the instructions in this letter. Questions regarding the lien or estate recovery rules should be directed to Barbara Edwards, Director of the Disabled and Elderly Health Programs Group, at (410) 786-0325. For all other issues addressed in this letter, please contact Eliot Fishman, Director of the Children and Adults Health Programs Group, at (410) 786-9535.

Sincerely,

/s/

Cindy Mann
Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
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Page 7 – State Medicaid Directors

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Medicaid Estate Recovery Program

By [Eugene Kiely](#)

Posted on [January 10, 2014](#) | Updated on [January 15, 2014](#)



[article on Dec. 15](#), under the headline “Expanded Medicaid’s fine print holds surprise: ‘payback’ from estate after death,” that said: “If you’re 55 or over, Medicaid can come back after you’re dead and bill your estate for ordinary health-care expenses.” The *Times* is right that the state of Washington has this power, but it was not in the “fine print” of the Affordable Care Act (as the story itself makes clear).

All states have had the option since Medicaid began in 1965 to recover some Medicaid costs from recipients after they die, as the Department of Health and Human Services explains in a [2005 policy brief](#). In 1965, it was optional and states could only recoup Medicaid costs spent on those 65 years or older. That changed in 1993, when Congress passed an omnibus budget bill that *required* states to recover the expense of long-term care and related costs for deceased Medicaid recipients 55 or older. The 1993 federal law also gave states the *option* to recover all other Medicaid expenses.

The Affordable Care Act did nothing to change existing federal law. It did, however, expand the number of people who are eligible for Medicaid, so there will be more people on Medicaid between the ages of 55 and 65, and, therefore, potentially more estates on the hook for Medicaid expenses after the beneficiary dies.

The gist of the *Times* story went viral in the blogosphere, where some blamed the ACA and/or questioned the motives of the Obama administration for expanding Medicaid. One [blog post](#) on the conservative Western Center for Journalism website — which carried the headline, “Obamacare Shocker: Strip Assets From Dead Seniors” — accused the administration of “deliberately turning the dead into cash cows.”

Medicaid Estate Recovery Program

Let’s first look at the origin of the recovery program. The HHS policy brief on state recovery programs said: “Since the beginning of the Medicaid program in 1965, states have been permitted to recover from the estates of deceased Medicaid recipients who were over age 65 when they received benefits and who had no surviving spouse, minor child, or adult disabled child.” Medicaid is a joint federal-state program that provides health care for the low-income and long-term care for the low-income elderly and disabled. The cost of long-term care, such as nursing home or community-based home health care, is substantial, and it is largely paid for by Medicaid. The HHS brief said Medicaid in 2002 paid “nearly half of the total amount spent on nursing homes.”

A [March 1989 report](#) by the General Accounting Office (now the Government Accountability Office) said that 21 states at the time established optional recovery programs, which the GAO found successful in offsetting the costs of long-term health care for Medicaid recipients. GAO recommended making the program mandatory and expanding it to include the estates of surviving spouses, not just deceased beneficiaries.

GAO, March 7, 1989

Omnibus Budget Reconciliation Act of

1993. That law also reduced the age of deceased recipients whose estates are subject to the recovery from 65 or over to 55 or over. Congress kept the prohibition on estate recovery in cases when there is a surviving spouse, a child under the age of 21 or a child of any age who is blind or disabled. In the cases of property, the law also carved out other exceptions for adult children who have served as caretakers in the homes of the deceased, property owned jointly by siblings, and income-producing property, such as farms.

All states now have Medicaid Estate Recovery Programs, although some were slow to create them. Michigan was one of the last to create one in 2007 after the federal government threatened to withhold federal Medicaid funds. A blog post on the website of a Michigan law firm that carried the headline "Now They Can Take Your Home: Estate Recovery Law Arrives in Michigan" said the state could have lost \$5 billion in Medicaid funds.

and whether the Congress should consider making mandatory the maintenance of
grants to states for the cost of federal assistance provided to nursing home residents of all ages under
of their states' budgets.
reported the case
of Michigan as an

The amount of money collected by states varies greatly, depending on how the state structures its program and how vigorously it pursues collections, according to Kristina Moorhead, state legislative representative for AARP. States recovered \$347.4 million in fiscal year 2003, ranging from a low of \$86,000 in Louisiana to a high of \$54 million in California, according to a 2005 AARP report. The total recovered was 0.13 percent of total Medicaid spending for the year. Moorhead told us that although federal law allows states to recoup all of their Medicaid costs, not just costs for long-term care, only 25 states do so.

AARP, June 2005: OBRA '93 allows recovery for "any items or services under the state plan," going beyond what is required by federal law (nursing facility services, home- and community-based services, and related hospital and prescription drug services). Twenty-five states reported recovery of "all other items under the state plan"; 10 states recover "some other items"; 10 states do not recover for any other services beyond what is required; and 1 state was DK/NR. A few states reported specific additional items for recovery as follows: ambulance, funeral, and burial costs (Illinois); costs of technological assistance such as motorized wheelchairs and readers for eye gestures (Kansas); transportation, dental services, and other services (Minnesota, New Jersey); physical therapy (Nevada); durable medical equipment, dental and vision services (Ohio); and PACE (Program of All-Inclusive Care for the Elderly) (Tennessee).

The Seattle Times said that the state of Washington expanded its program in 2004 to cover "all medical services for Medicaid clients." That was the case when the *Times* wrote its story. But the state has since changed the rules to limit the program to what is required under federal law: the recovery of state Medicaid expenses for long-term care and related costs.

Enter the Affordable Care Act

Moorhead, of AARP, said the Affordable Care Act did not change the federal law governing the Medicaid Estate Recovery Program. In fact, nothing changes for seniors 65 or older who apply for and receive Medicaid to pay for long-term care. (Medicare covers some costs for up to 100 days of long-term care, such as a stay in a nursing home. Beyond that, low-income seniors can apply for Medicaid to cover expenses.)

The ACA, however, does three things that potentially will subject more people between the ages of 55 and 65 and their assets to the Medicaid recovery program:

Mandates that most Americans have health insurance. The law requires Americans, with some exceptions, to purchase a qualified health insurance plan or pay a penalty. The penalty this year will start at \$95 per person or 1 percent of household income, whichever is higher, and increases until it reaches 2.5 percent or \$695 per person in 2016.

Expands eligibility for Medicaid. Medicaid has been largely limited to low-income children, parents, pregnant women, the disabled and elderly. "While states have increasingly expanded eligibility for children over time, eligibility for parents remains much more limited, and only nine states provide full Medicaid coverage to low-income adults without dependent children," according to the nonpartisan Kaiser Family Foundation. The ACA expanded Medicaid, beginning in January, to include nearly all non-disabled adults under age 65 with household incomes "up to

138% FPL (\$31,809 for a family of four in 2012), which would make millions of currently uninsured adults newly eligible for the program," [the Kaiser Family Foundation says](#). The ACA mandated the expansion, but the U.S. Supreme Court ruled that states can opt out. [Half of them so far have done so](#).

Eliminates assets test from eligibility requirements. As the [American Public Health Association](#) explains, Medicaid eligibility "is complicated, and varies from state to state. It involves calculations of income and assets, as well as 'disregards' of income and assets that vary for different populations." But, [as AARP explains](#), the ACA created an "additional set of rules" based on income, specifically Modified Adjusted Gross Income. "[I]mportantly, it doesn't count assets," says the APHA.

Those who are eligible for Medicaid under the ACA expansion are *not* eligible for government subsidies to buy private insurance on state or federal health exchanges, so they have little choice but to accept Medicaid. For this reason, the Western Center for Journalism blog item says the individual mandate provision of the ACA will "force" people into Medicaid and then "strip" them of their assets after they die. "Since this despicable plot was exposed by the *Seattle Times*, a number of states have vowed to change estate recovery rules as revised by ObamaCare," the blog post says. (Again, the estate recovery rules were not "revised by Obamacare.")

The IRS, which levies the penalties for not complying with the Affordable Care Act, says it will provide a hardship exemption for certain low-income people who cannot afford insurance even with the subsidies, and it will provide an exemption for people who are otherwise eligible for the Medicaid expansion but live in states that don't offer it.

Update, Jan. 15: A Treasury official also told us it is "very unlikely" that someone who refuses to sign up for Medicaid and cannot afford private insurance would be subject to a fine. That person would likely be eligible for one of at least three exemptions, including a financial hardship exemption.

The interaction of the federal Affordable Care Act and existing state Medicaid estate recovery laws is a legitimate issue and something that Medicaid recipients need to understand before they sign up. They should know that the rules vary from state to state, with some states dunning the estates of deceased Medicaid beneficiaries for all Medicaid costs and others just for long-term care. And the rules keep changing. AARP's Moorhead says so far two states (Washington and Oregon) have changed their rules to limit estate recovery to Medicaid costs related to long-term care, as required by the 1993 federal law.

Elaine Ryan, AARP's vice president of state advocacy and strategy integration, says the senior group is not lobbying for state changes to the Medicaid Estate Recovery Programs — at least not yet. "This is all so new and we're still trying to unpack how the different states apply the recovery rules," she said. "We're still looking at what makes sense."

Those who are Medicaid-eligible under the ACA also should know that the 1993 federal law bars estate recovery when there is a surviving spouse, a child under the age of 21 or a child of any age who is blind or disabled. And that there are exemptions that will allow other family members to keep the family farm or home under certain circumstances.

And they should know that the Affordable Care Act didn't create Medicaid estate recovery rules or revise them. ACA merely expanded access to health care for millions of uninsured low-income people.

— Eugene Kiely

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Medicaid's New Adult Group and Estate Recovery

Since 1993, state Medicaid programs have been required to pursue recovery from the estates of deceased beneficiaries for long-term services and supports (LTSS) benefits paid on their behalf. Although there are no requirements for recovery for other types of services, 35 states and the District of Columbia have elected to do so. Twenty-three of these states and the District of Columbia have also expanded Medicaid to non-disabled adults under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). Media reports have highlighted concerns that some newly eligible adults may choose not to enroll in Medicaid due to fears of the risk of estate recovery. This brief provides an overview of current Medicaid policy on estate recovery and its rationale, including states' and the Centers for Medicare & Medicaid Services' (CMS) efforts to limit estate recoveries.

Current Law

Since the inception of the program, state Medicaid programs have been permitted to recover assets from the estates of certain beneficiaries as reimbursement for the care provided to them. In 1993, the Omnibus Budget Reconciliation Act (OBRA, P.L. 103-66) made estate recovery mandatory for three categories of beneficiaries under certain circumstances¹: (1) individuals who were expected to be permanently institutionalized; (2) individuals who received Medicaid when they were age 55 or older; and (3) individuals with long-term care insurance policies. In a hearing prior to the passage of OBRA, supporters of mandated estate recovery testified that such a policy would ensure that Medicaid funding was used for the truly needy, and could also supplement Medicaid funding by recouping funds spent on deceased beneficiaries (Goldberg 1993, Rohlfs 1993). Since that time, state officials have said that the revenue brought in from estate recovery would allow states to spend more on Medicaid, and would help states avoid service reductions when budgets are tight (Karp et al. 2005).

Beneficiaries who receive LTSS qualify through eligibility pathways that include assets tests. Estate recovery requirements are an additional method to insure that assets available to beneficiaries are used to pay for their care, while protecting their use of some of those assets (e.g., their homes) during their lifetimes.

For beneficiaries age 55 or older receiving Medicaid, OBRA specified benefits for which Medicaid programs are required to seek recovery (Table 1). Specifically, Medicaid programs are required to seek recovery for amounts at least equal to benefits paid for nursing facility services, home and community-based services (HCBS), and related hospital and prescription drug services (those provided during a stay in a nursing facility or while receiving HCBS).

In addition, states are allowed the option of seeking recovery for any other items or services under their state plan, including capitated payments made to managed care plans. As of 2014, 35 states and the District of Columbia pursued estate recovery for non-LTSS services (Morgan 2014). Recoveries may not exceed the total amount spent by Medicaid on the individual's behalf at or after age 55.



TABLE 1. Current Requirements for Benefit Categories States Must Pursue for Estate Recovery

Requirement	Benefit categories
Mandatory	Nursing facility services Home and community-based services (HCBS) Hospital and prescription drug services related to care in a nursing facility or HCBS
Optional	Any or all other items and services under the state plan (excluding Medicare cost-sharing)

Source: MACPAC analysis of the Social Security Act, as amended by DBRA.

Policy Questions Surrounding the New Adult Group

In the 23 states and the District of Columbia that have expanded Medicaid, and where policies exist to pursue estate recovery for the optional non-LTSS benefits, a new dynamic is potentially in play (Figure 1). Individuals now eligible for Medicaid under the new adult group could be subject to estate recovery for benefits they receive when they are age 55 or older.

FIGURE 1. States That Have Expanded Medicaid and Pursue Estate Recovery for Benefits Other Than LTSS, November 2015

- Expanding – recover payments for non-LTSS benefits (23 states and DC)
- Not expanding – recover payments for non-LTSS benefits (12 states)
- Expanding – do not recover payments for non-LTSS benefits (7 states)
- Not expanding – do not recover payments for non-LTSS benefits (8 states)



Notes: Oregon only pursues estate recovery for any non-LTSS benefits when LTSS services were also received by a beneficiary.
Sources: MACPAC analysis of Morgan 2014, CMS 2015a, CMS 2015b, DEHPG 2015, CMS 2014a, CMS 2014b, CMS 2014c, CMS 2014d, CMS 2014e, CMS 2014f, CMS 2014g, CMS 2014h, CMS 2014i, CMS 2014j, CMS 2014k, CMS 2014l, CMS 2014m, CMS 2014n, CMS 2014p, CMS 2014q, CMS 2014r, CMS 2014s, CMS 2014t, CMS 2014u, CMS 2014v, CMS 2013a, CMS 2013b, CMS 2013c, CMS 2013d, DPW 2015, Office of the Attorney General 2012, Office of Governor Bill Walker 2015, Office of Governor Steve Bullock 2015, and Office of Governor Jack Markell 2012.



Seeking recovery from the estates of beneficiaries eligible under the new adult eligibility rules and age 55 or older raises a number of questions, including:

Is estate recovery a barrier to enrollment for the new adult group?

Recent media reports suggest that some individuals in states that have expanded Medicaid to low-income adults are not enrolling because of fears of estate recovery (Aliferis 2015, Armour 2015, Brown 2014, Mullen 2014, Schilling 2015). Although data are not available to assess how widespread this fear is and its overall effect on enrollment, individuals that forgo Medicaid coverage for this reason would be exposing themselves to individual mandate penalties and the health and financial risks of remaining uninsured.

Do estate recovery rules conflict with the intent of the ACA MAGI rules?

Individuals in states that have expanded Medicaid are deemed eligible based on modified adjusted gross income (MAGI). Unlike most Medicaid populations who qualify for the program under pathways that give them access to LTSS, they are not subject to an assets test. The purpose of eliminating assets from eligibility determination for the new adult group was to align determinations of eligibility with subsidies for the exchange coverage. Given that there is no requirement to "spend down" assets to be eligible for Medicaid coverage for the new adult group, pursuing their estates for repayment may be inconsistent with the eligibility determination.

Do estate recovery requirements create inequity between Medicaid enrollees and those in the exchanges?

Pursuing estate recovery for non-LTSS benefits raises questions of equity between individuals qualifying for Medicaid and those who receive subsidized coverage through the exchanges. Individuals who receive subsidized coverage through the exchanges are not subject to estate recovery. This means that only the lowest income individuals who qualify for Medicaid rather than exchange subsidies (those under 138 percent of the federal poverty level) would be subject to estate recovery.

State and Federal Responses

States have flexibility to change their policies regarding pursuing estate recovery for non-LTSS benefits. A number of states that have expanded Medicaid have recently taken steps to do so. Connecticut, Colorado, and Washington have made amendments to their Medicaid state plans to eliminate recovery for non-LTSS benefits, and Oregon now only pursues recovery for non-LTSS services if LTSS services were also received (DEHPG/CMCS/CMS 2015).

* In addition, in 2014 CMS sent a letter to state Medicaid directors stating that the agency was exploring options to use its available authorities to eliminate recovery of Medicaid benefits consisting of items or services other than LTSS and related services for individuals in the new adult group (CMS 2014o). *
However, the agency has not taken any further action since that time.

•••

Promising Practices and Model Notices Studies
Conclusions and recommendations for required
notification.

#2007-07
May 2007

**Protections in Medicaid Estate Recovery:
Findings, Promising Practices, and Model Notices**

by

Erica F. Wood

Ellen M. Klem

ABA Commission on Law and Aging

The AARP Public Policy Institute, formed in 1985, is part of the Policy and Strategy Group at AARP. One of the missions of the Institute is to foster research and analysis on public policy issues of importance to mid-life and older Americans. This publication represents part of that effort.

The views expressed herein are for information, debate, and discussion, and do not necessarily represent official policies of AARP.

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Executive Summary

Protections in Medicaid Estate Recovery: Findings, Promising Practices and Model Notices

Background and Status of Estate Recovery

Purpose and Overview

More than 55 million Americans rely on the joint federal-state Medicaid program for their health care and long-term care. Medicaid, the nation's largest public health insurance program, pays for almost half of all spending on long-term care. An indigent nursing home resident with dementia, a young person with mental retardation in an intermediate care facility, an older, middle-income nursing home resident who has "spent down" private resources, or a couple receiving home and community-based care—all may be beneficiaries of the Medicaid program. Medicaid enrollment and spending spiraled sharply during the 2001 recession and thereafter, and while it has slowed somewhat, state and federal pressure to limit Medicaid spending remains high.

In light of these pressures, estate recovery is one approach to replenish state funds. Estate recovery has been a federal mandate for 14 years. In 1993, Congress sought to recoup the costs of long-term care and other related Medicaid services by requiring that states implement estate recovery programs. The Centers for Medicare and Medicaid Services (CMS) have issued guidelines in the *State Medicaid Manual* that afford states considerable flexibility in implementation. In response, states have initiated laws, regulations, and programs to recover funds from the estates of institutionalized Medicaid recipients and those who were age 55 or older when they received Medicaid, as well as certain additional recipients designated by law. Estate recovery makes Medicaid for institutionalized and older people very different from most federal benefit programs.

In 2005, the ABA Commission on Law and Aging completed a nationwide survey for the AARP Public Policy Institute assessing the status of state estate recovery programs (referred to as the 2005 study). The survey concluded by asking "whether more rigorous and uniform notice and other procedural protections, as well as broader outreach, could check misperceptions about estate recovery and ensure the effectiveness of hardship waiver requirements." Thus, in 2006, the Institute asked the ABA Commission to conduct a more limited follow-up study focusing on such protections and identifying effective practices for replication.

The aim of this follow-up study was to: (1) provide CMS, state estate recovery officials, policy makers, advocates, and the legal community with information about current state practices concerning public information and procedural protections; and (2) assist states in developing procedures that give Medicaid beneficiaries and survivors timely, clear, and accurate information and that include necessary safeguards. This report represents the study findings and serves as a resource for states, highlighting readily usable practices that could benefit both the programs and the affected populations.

Study Methodology

The study examined state approaches to: (1) public information; (2) notice; (3) procedures for waiving estate recovery because of undue hardship on the survivors; (4) procedures that states use to make collections directly from banks and nursing homes rather than relying solely on the judicial claim process; and (5) state data collection on estate recovery, as solid statistics are needed to fully evaluate the impact on beneficiaries and survivors and the effectiveness of the state programs.

The study had five components: (a) a brief e-mail survey of Medicaid officials; (b) identification of amounts collected; (c) collection and review of claim and lien notices, brochures, and Web sites; (d) telephone discussions with Medicaid officials from selected states; and (e) identification of practices for replication and development of model notice forms.

Thirty-five states (including the District of Columbia) responded to the e-mail survey; two states did not have a program in operation, one state's program was an inactive, one state declined to participate, and 12 states did not respond.

Status of Programs

Fifty of the 51 states (including the District of Columbia) have a Medicaid estate recovery program. As of this writing, Michigan had no program, and Georgia was in the process of implementing one. New Mexico reported an inactive program.

Amounts Collected

Recovery amounts are increasing at a modest rate, and the financial impact of estate recovery on state budgets remains slight but not insignificant. Amounts collected through estate recovery represent between 0.01% and 2.09% of total state long-term care Medicaid expenditures, with only six states above 1%. The average proportion has remained constant at 0.61% (FY 2005), compared with 0.63% (FY 2003) two years earlier, as reported in the 2005 study.

The amount recovered nationally in FY 2005 was \$411,133,981—almost \$81 million more than in FY 2003. The average state recovery was \$8,061,451, compared with \$6,477,206 in FY 2003.

Protections for Beneficiaries and Survivors

Estate recovery makes the Medicaid program very different from most federal benefit programs; to the extent possible, the amount of the benefits is eventually returned to the government. This fact is critical for applicants, beneficiaries, and survivors to understand, and is important to communicate to them clearly at multiple points and through multiple channels, from consideration of an initial application to the actual collection of funds.

CMS guidance indicates that states should provide a general notice of estate recovery at the time of Medicaid application. This is a cornerstone of fairness. Applicants need to be aware that by enrolling in the program, they are agreeing to give back at a later time the value of the care received, that is, the care comes with the caveat that the estate eventually will pay the state back.

All responding states give notice of estate recovery at application. However, this notice is generally a one-line or brief paragraph reference in the lengthy Medicaid application form. It often is included in a long list of many competing and important beneficiary "rights and responsibilities" and the enrollee frequently must sign to indicate that he or she has reviewed and understands the list. Because it is difficult to absorb all of this information during the eligibility process, some states give the applicant a brochure, but this practice is not uniform across and within states.

Some states give notice of estate recovery at additional points as well as at application: 14 give notice at redetermination of eligibility, and 13 at admission to a certified facility.

Whether a better understanding of estate recovery at application (and following points) would deter a significant number of older people and others, who could qualify for Medicaid long-term care services (including home and community-based waiver services), from applying is not known.

The study identified approaches to highlight information about recovery at application and other key points.

Pre-Death Lien Notice

Federal Medicaid law allows states to impose pre-death or "TEFRA" liens on the homes of living Medicaid recipients determined to be "permanently institutionalized" and not likely to return home. Both federal law and CMS guidelines require notice and opportunity for a hearing on determination of permanent institutionalization for placement of a TEFRA lien.

A TEFRA lien notice is addressed to a living Medicaid recipient whose property interests are at stake. Moreover, the property generally is a home, often a lifetime one. By definition the institutionalized recipient is frail and frequently is cognitively impaired, and he or she may or may not have a legally authorized surrogate acting on his or her behalf.

Currently 22 states report having authority to place pre-death TEFRA liens on the homes of living Medicaid recipients determined to be permanently institutionalized. However, not all of these states actually impose such liens. Twelve of the 22 states with TEFRA lien authority have notices of permanent institutionalization and intent to place a lien, as required by federal law and CMS guidelines; eight did not respond; one has no written notice but uses an alternative procedure; and one did not know.

Lien notices vary significantly in the key information they include, such as how permanent institutionalization is determined (included by nine of the 12 examined); a

recovery. Indeed, in analyzing responses to the survey questionnaire, project staff encountered numerous inconsistencies, serious gaps, and possible data errors that required further checking and hindered evaluation of the results.

While most responding states (23) have a computerized system to collect basic estate recovery statistics, many track only the number of estates against which recovery was completed. The specific data elements collected vary considerably, with only some states able to report the number of exemptions and deferrals (17 of the responding states), number of hardship waivers requested (21) and granted (24), number of recoveries contested (12), number of recovery settlements (18), sources of property (real versus personal) from which recovery was made (13), and the number of pre-death liens (nine).

Only 20 states reported tracking total administrative costs of their estate recovery efforts (such as staff, facilities and support, information systems, and legal costs), and only three states (Alabama, District of Columbia, and Nevada) publish estate recovery data regularly. This report lists elements for effective data collection.

Conclusions and Recommendations

Estate recovery and accompanying lien policies directly affect specific individuals—frail residents of long-term care facilities whose homes are subject to liens, surviving spouses, and other family members or potential heirs of deceased Medicaid recipients. States may face a challenge in balancing the competing social goals of protecting these populations and maximizing collections to replenish state budgets. This study investigated protections currently used, revealing wide variations among states in public information, notice, hardship waiver procedures, direct collections, and maintenance of data for program evaluation. The study stands as a resource for states by identifying the variations and highlighting some readily usable practices that could benefit both the state recovery programs and the populations affected.

Conclusions

1. While increases in amounts collected through estate recovery are modest, they may cause hardship and thus signal the need for solid protections. In the last two years, the average state recovery increased by 24% but remained steady at a very small proportion of annual Medicaid long-term care expenses—a mere 0.61%, compared with 0.63% two years earlier. While estate recovery is making only very modest contributions to state budgets, it affects family members and other heirs, some of whom require protection through exemptions, deferral, and hardship waivers, and all of whom are entitled to meaningful notice.

2. Early information and notice can best protect beneficiaries and heirs and facilitate the smooth operation of state recovery programs. Clearly written brochures that are distributed routinely and consistently, in English and other languages, as well as user-friendly Web sites, clear application notices, explanations of recovery at the point of eligibility, and training eligibility and other staff can help to avoid misperceptions and encourage informed Medicaid decisions.

3. Public information, pre-death lien notices, and claim notices vary widely in content and clarity. The promising practices identified in this study could improve public understanding and safeguard rights. Meaningful notice is the foundation of procedural due process. Notice of a state's intent to place a pre-death lien is particularly critical for vulnerable residents of long-term care institutions. Notice is also crucial for surviving spouses, who may depend on financial transactions involving the property. A claim notice needs to clearly inform potential heirs, who may have low or moderate incomes and may be depending on the property, of the pending recovery and opportunities for exemption or waiver. Notices that these individuals can understand also saves scarce staff time and helps to inspire public trust.

4. States give claim notices at different points, which bears directly on the protections required. Some states wait for the formal court probate process to give notice of recovery, when judicial protections are in place and the vast majority of those affected are represented by attorneys. Others give notice as soon as they learn of the death of the Medicaid recipient. In the latter case, individuals may not have legal representation and may not be fully informed about exemptions and waivers, making clear and understandable information especially critical. Identifying and informing "individuals affected" is problematic for Medicaid agencies.

5. Direct recovery of funds from banks through small estates affidavit and similar procedures are subject to the same protections as other estate recovery. This precludes recovery when there is a known surviving spouse and others who are exempt. However, it may be difficult to identify exempt individuals and other "individuals affected" to give notice of an opportunity to contest the recovery. If such individuals are not known, state agencies and banks can at least provide a period for exempt individuals to collect the funds before proceeding with recovery.

6. The number of undue hardship waiver requests submitted has decreased markedly in the last two years. Hardship waivers are a safeguard and a bulwark against impoverishment of the decedent's heirs. Thus, for the estate recovery program to work as intended, balancing the need to replenish state funds with adversity in individual situations, the waiver process must be clear and readily available in appropriate circumstances. In the last two years, the number of waiver applications submitted has decreased substantially, possibly due to an increase in public information (which may, in turn, result in fewer waiver submissions that are not responsive to the criteria), tightened waiver eligibility standards, or both. At least one state has no specific criteria for hardship waivers.

7. As in 2005, the lack of basic data collection impairs assessment of recovery efforts, including use of protections. Collecting data on most elements of estate recovery, including basic elements of protection such as deferrals and exemptions, as well as hardship waivers, is inconsistent across states and, in fact, largely lacking in many. This makes it difficult to discern patterns of implementation, and it was a substantial barrier for the study.

Recommendations

To protect beneficiaries and other affected populations affected by estate recovery, the study urges that:

1. States review and consider the promising practices identified in this report. These practices include user-friendly brochures, Web sites, information in languages other than English, clear notice at the point of Medicaid application, basic training of eligibility staff, understandable notice about pre-death liens and claims, use of hardship waiver forms, and development of clear appeal procedures, along with routine collection of basic recovery data. These practices all offer low-cost, high-impact opportunities for estate recovery programs to enhance efficiency and further the understanding of beneficiaries, families, and the public.

2. States emphasize early notice of recovery. Government recoupment of funds makes Medicaid long-term care different from most public benefit programs. States need to alert beneficiaries and families to this fact by bolstering public information and ensuring their understanding through oral explanation and clear written notice at the point of application.

3. States that send notice of recovery directly following the death of Medicaid recipients reexamine this approach. Initiating recovery at death instead of waiting for probate targets an uncertain audience that frequently lacks legal representation or other sources of assistance. This practice bears careful scrutiny and at a minimum requires attention to ensure that the claim notice is easy to understand, includes all key information, and is accompanied by a fact sheet or brochure with full contact information.

4. States that recover directly from banks recognize exemptions and build in key protections. First, states need to recognize that spouses and other exempt populations are excluded from direct recovery of bank accounts, to the extent they can be identified. Banks need to recognize these exempt populations as well. Second, states need to alert Medicaid recipients at the time of application and through public information channels that monies may be subject to recovery through commingling of funds in joint accounts with nonexempt populations.

5. CMS review the report's description of promising practices and the model notice forms and consider offering guidance to states. A wide range of reviewers have agreed that the promising practices highlighted in the report would enhance the state programs, and that the model claim notice and lien notice forms include all key information presented in language and format best understood by those who may be affected. CMS could urge states to adapt the practices and forms, thus encouraging uniformity and consistency among the states, yet allowing for needed flexibility.

6. CMS consider setting out basic data elements for estate recovery and recommending formats for reporting them consistently and making the results publicly available. Such consistent collection of data across states would help CMS, state agencies, and the public to identify trends and better assess recovery efforts. Important elements might include at least the number of estates against which recovery was completed, exemptions or deferrals, hardship waivers (submitted, granted, denied), and pre-death liens. In addition, more consistent state reporting practices to CMS concerning amounts collected would provide a more precise picture of estate recovery nationally and how states compare to one another.

Chapter 3:

Medicaid Estate Recovery: Improving Policy and Promoting Equity

and is a good return on investment (OIG 1995, Goldberg 1993, Rohlfes 1993). State officials have also indicated that estate recovery allows states to spend more on other aspects of Medicaid (Karp et al. 2005). One of the states we surveyed noted that estate recovery is an important source of funding, reserves Medicaid for those with a true financial need, and ensures that Medicaid is the payer of last resort. An interviewee described estate recovery as an important reminder of the cost of long-term care, for which Medicaid is the nation's largest payer.

Criticism of Medicaid estate recovery policy

Critics of Medicaid's estate recovery policy say that it punishes low-income families and recovers little (Corbett 2019). Medicaid beneficiaries generally have few assets, particularly given that most individuals must meet asset limits to qualify for coverage of LTSS (CHCF 2014). As we heard in our interviews with stakeholders, individuals with greater awareness of estate recovery and resources may protect their assets from estate recovery while preserving Medicaid eligibility, allowing resources to be passed on to their heirs. Stakeholders noted that individuals with little income and few assets besides a home, however, are less likely to be aware of estate recovery or have the resources to obtain an attorney. In addition, unless someone is able to protect assets, Medicaid eligibility rules require they impoverish themselves, except for assets that are not counted toward eligibility, as noted above. As a result, the estates that actually get pursued by states are usually modest in size. For heirs of these modest estates, estate recovery may remove a source of income or a residence which, if retained, would protect the heirs from poverty or housing insecurity. As multiple interviewees commented, this contributes to generational poverty and wealth inequality. The policy may also place an unequal burden on people of color, compounding existing wealth inequalities among racial and ethnic groups. Finally, Medicaid estate recovery policies are unique among federal programs. For example, many people who use LTSS are dually eligible for Medicare and

Medicaid, yet as one advocate noted, the federal government does not pursue Medicare costs, which can also be quite high (Corbett 2019).

Program Administration

Estate recovery administration is complex and involves a number of steps to notify potential Medicaid beneficiaries, assess and verify assets, inform survivors of estate recovery claims, initiate recovery through the probate process or other means, and provide exceptions in the case of potential hardships. State agencies can perform these tasks or use third-party contractors to carry out some of this work.

Providing public information and meaningful notice

States are required to provide notice to Medicaid applicants explaining the estate recovery policy. A 2005 survey found that all responding states provided notice at the time of application; a minority of states also provided notice at other points such as during eligibility redetermination or upon admission to a certified facility. Those conducting that survey found that the information provided to beneficiaries lacked detail, raising questions about how well applicants comprehended the notice (Wood and Klem 2007).

PLEASE NOTE LACKED Detail!

Some states use websites, brochures, and toll-free numbers to educate beneficiaries and their representatives on estate recovery requirements. For example, the District of Columbia has a fact sheet on its website with information including the definition of an estate and the procedure for applying for a hardship waiver (DC DHCF 2015). Kansas has a similar fact sheet, and Nebraska's website has a brochure on estate recovery and several related forms (NE DHHS 2020, KS DHE 2017). However, our stakeholder interviews suggest that awareness of estate recovery remains low.

Effects of Estate Recovery on Seeking Medicaid Coverage

A criticism of estate recovery policies is that they reduce access to Medicaid-covered LTSS. In our stakeholder interviews, beneficiary advocates, elder law attorneys, and state officials all commented that some people choose to forego or delay Medicaid LTSS for fear of estate recovery and losing their home. As one interviewee noted, this can lead to poor health outcomes.

Although stakeholders could not quantify how many individuals are deterred from seeking Medicaid LTSS due to estate recovery, prior research noted it as a barrier to enrollment in Medicare Savings Programs (MSPs), which provide assistance with Medicare cost sharing (Nemore 2007, Sanchez 2007). As such, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) barred estate recovery collections for premiums, deductibles, and coinsurance made on behalf of individuals participating in MSPs. In addition, as noted earlier, estate recovery as a deterrent to Medicaid enrollment was also raised as a concern for the new adult group when the Commission last explored this issue (MACPAC 2015, Schilling 2015, Brown 2014). A number of states subsequently eliminated estate recovery from populations that they are not required to pursue (MACPAC 2015).

Although fear of estate recovery may deter some individuals from seeking Medicaid LTSS, awareness and understanding of estate recovery policies by the general public and by Medicaid beneficiaries is low. As noted previously, individuals may first learn about estate recovery during the Medicaid application process, as information is included in the rights and responsibilities section of the application. Two stakeholders, however, noted that this can get lost in the fine print of long applications, and questioned how many people read or understand that information. Additionally, interviewees noted that individuals who have urgent needs for services may not have the time or ability to consider estate recovery policies. Finally,

one stakeholder pointed out that even though a Medicaid beneficiary may be aware of estate recovery, if they do not pass that information along to the beneficiaries of their estate, it can come as a shock to those individuals after the enrollee's death.

Commission Recommendations

As the Commission deliberated on estate recovery we drew several conclusions. First, estate recovery does not appear to be effective in recouping assets from the estates of beneficiaries with substantial means. Instead, the modest average recovery amounts reported in our survey and comments from stakeholder interviews suggest that states primarily collect from estates of modest size. Because wealthier beneficiaries have found ways to protect assets so they can be passed on to their heirs, current Medicaid estate recovery policy places an unfair burden on beneficiaries with limited means, whose heirs would likely receive substantial protection from poverty or housing insecurity if they were able to retain an estate of even modest size. While seeking ways to correct this situation, the Commission sought to introduce greater state flexibility and ensure minimum federal protections for beneficiaries and their heirs.

The Commission's deliberations resulted in three recommendations. Congress could take up these recommendations independently of each other, but if the first recommendation is adopted, then the second two would only apply in states that continue recovery. Below we share our rationale and implications for these recommendations. We also share estimates by the Congressional Budget Office (CBO) of how these recommendations would affect the federal deficit. As is typical for MACPAC recommendations, CBO produced estimates within specified ranges because the recommendations did not include legislative language that would enable a more detailed estimate.



Ohio Revised Code

Section 1345.02 Unfair or deceptive acts or practices.

Effective: April 6, 2017

Legislation: Senate Bill 227 - 131st General Assembly

(A) No supplier shall commit an unfair or deceptive act or practice in connection with a consumer transaction. Such an unfair or deceptive act or practice by a supplier violates this section whether it occurs before, during, or after the transaction.

(B) Without limiting the scope of division (A) of this section, the act or practice of a supplier in representing any of the following is deceptive:

- (1) That the subject of a consumer transaction has sponsorship, approval, performance characteristics, accessories, uses, or benefits that it does not have;
- (2) That the subject of a consumer transaction is of a particular standard, quality, grade, style, prescription, or model, if it is not;
- (3) That the subject of a consumer transaction is new, or unused, if it is not;
- (4) That the subject of a consumer transaction is available to the consumer for a reason that does not exist;
- (5) That the subject of a consumer transaction has been supplied in accordance with a previous representation, if it has not, except that the act of a supplier in furnishing similar merchandise of equal or greater value as a good faith substitute does not violate this section;
- (6) That the subject of a consumer transaction will be supplied in greater quantity than the supplier intends;
- (7) That replacement or repair is needed, if it is not;
- (8) That a specific price advantage exists, if it does not;



- (9) That the supplier has a sponsorship, approval, or affiliation that the supplier does not have;
- (10) That a consumer transaction involves or does not involve a warranty, a disclaimer of warranties or other rights, remedies, or obligations if the representation is false.
- (C) In construing division (A) of this section, the court shall give due consideration and great weight to federal trade commission orders, trade regulation rules and guides, and the federal courts' interpretations of subsection 45 (a)(1) of the "Federal Trade Commission Act," 38 Stat. 717 (1914), 15 U.S.C.A. 41, as amended.
- (D) No supplier shall offer to a consumer or represent that a consumer will receive a rebate, discount, or other benefit as an inducement for entering into a consumer transaction in return for giving the supplier the names of prospective consumers, or otherwise helping the supplier to enter into other consumer transactions, if earning the benefit is contingent upon an event occurring after the consumer enters into the transaction.
- (E)(1) No supplier, in connection with a consumer transaction involving natural gas service or public telecommunications service to a consumer in this state, shall request or submit, or cause to be requested or submitted, a change in the consumer's provider of natural gas service or public telecommunications service, without first obtaining, or causing to be obtained, the verified consent of the consumer. For the purpose of this division and with respect to public telecommunications service only, the procedures necessary for verifying the consent of a consumer shall be those prescribed by rule by the public utilities commission for public telecommunications service under division (D) of section 4905.72 of the Revised Code. Also, for the purpose of this division, the act, omission, or failure of any officer, agent, or other individual, acting for or employed by another person, while acting within the scope of that authority or employment, is the act or failure of that other person.
- (2) Consistent with the exclusion, under 47 C.F.R. 64.1100(a)(3), of commercial mobile radio service providers from the verification requirements adopted in 47 C.F.R. 64.1100, 64.1150, 64.1160, 64.1170, 64.1180, and 64.1190 by the federal communications commission, division (E)(1) of this section does not apply to a provider of commercial mobile radio service insofar as such



provider is engaged in the provision of commercial mobile radio service. However, when that exclusion no longer is in effect, division (E)(1) of this section shall apply to such a provider.

(3) The attorney general may initiate criminal proceedings for a prosecution under division (C) of section 1345.99 of the Revised Code by presenting evidence of criminal violations to the prosecuting attorney of any county in which the offense may be prosecuted. If the prosecuting attorney does not prosecute the violations, or at the request of the prosecuting attorney, the attorney general may proceed in the prosecution with all the rights, privileges, and powers conferred by law on prosecuting attorneys, including the power to appear before grand juries and to interrogate witnesses before grand juries.

(F) Concerning a consumer transaction in connection with a residential mortgage, and without limiting the scope of division (A) or (B) of this section, the act of a supplier in doing either of the following is deceptive:

(1) Knowingly failing to provide disclosures required under state and federal law;

(2) Knowingly providing a disclosure that includes a material misrepresentation.

(G) Without limiting the scope of division (A) of this section, the failure of a supplier to obtain or maintain any registration, license, bond, or insurance required by state law or local ordinance for the supplier to engage in the supplier's trade or profession is an unfair or deceptive act or practice.