FILED
ATHENS COUNTY, OHIO
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OF COMMON PLEAS COURT

IN THE ATHENS COMMON PLEAS COURT

ATHENS COUNTY, OHIO

DOROTHY DOWLER,

APPELLANT.

V.

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES,

APPELLEE.

CASE NO. 15 CI 0028

JUDGE
GEORGE McCARTHY

**DECISION ON APPEAL**

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Appellant appeals a January 22, 2015 decision by Appellee Ohio Jobs and Family Services concerning Medicaid coverage. Within that decision, Appellant was determined to have a restricted period of Medicaid coverage from April 2012 into a partial month of January 2017. Appellant challenges the Appellee's determination of the start date of the Medicaid restricted coverage period. Appellant also challenges the sufficiency of the evidence in this case and asserts that the burden of proof was improperly shifted to Appellant. Appellant also alleges that the Appellee failed to determine monthly benefits pursuant to the administrative rules.

## PROCEDURE OF THE CASE AND FINDINGS OF FACTS

After review of the record the Court makes the following findings of fact and determinations. Appellant gifted monies to family members within the five year (60 month) Medicaid lookback period. Appellant was admitted to a nursing home in March 2011 and made application for Medicaid coverage. Appellant's Medicaid coverage began April 2011. Once enrolled, Appellee conducted a resources search. Subsequently, it was determined Appellant transferred monies to family members some of which went into a trust. Gifted monies were determined to be within the sixty month look back period and subject to being counted as a resource for purposes of determining eligibility for Medicaid coverage.

Ultimately, Appellee found Appellant to have improperly transferred $344,705.88 within the sixty month lookback period and required this amount to be paid back to Appellant to be eligible for additional Medicaid coverage. Because of the improper transfer of $344,705.88, Appellee determined that Appellant was over resourced for purposes of calculating her monthly Medicaid eligibility. Generally, to be eligible for Medicaid coverage, a person must have no more than $1500 in resources per month.

Because Appellee found that the previously transferred amount was improper, Appellee imposed a restricted period of Medicaid coverage beginning April 2011. As of April 2014, Appellant's family had returned $180,814.41 of this amount to Appellant. The remaining $163,891.47 is the remaining improperly gifted amount after the return of $180,814.41.

At the 8/21/14 State Hearing, that hearing officer listed previous calculations made by the Agency (Ohio Jobs and Family Services) that led to the Agency to assert that the beginning of the Medicaid coverage restricted period should be April 2012. The Agency used figures of $120,398.88 and a nursing home average pay rate of $6,114.00 in its calculations. Although the

1/22/15 state hearing officer noted the internal inconsistency of this decision, the State Appeal Hearing Decision modified the restricted period date to begin April 2012 finding that it could not place Appellant in a worse position with a finding of a later start date of April 2014.

In the State Appeal Hearing Decision of 1/22/15, Appellee reasoned that the coverage period should have begun when Appellant was eligible for Medicaid coverage and determined that date was April 2014. However, the 1/22/15 hearing officer established the restricted period as of April 2012 based upon what was contained in the 8/21/14 Hearing Decision.

The parties agree that currently, the restricted period should be 27.21 months. This is based upon the remaining $163,891.47 amount of Appellant's improperly transferred monies still outstanding. *See Administrative Appeal Decision, 1/22/15, p. 2.* Appellant appeals to this Court asserting that the 27.21 month restricted Medicaid coverage period should begin April 2011. Appellee believes that the period should begin April 2014, but concedes that the period should begin April 2012 because of an administrative rule prohibiting placing the applicant in a worse position than she was prior to the appeal.

On 12/11/13 the Appellee determined, and the parties agree, that Appellant improperly transferred $344,705.88 within the sixty month lookback period. That amount was relied upon by the Appellee to determine resources for Medicaid coverage eligibility. *See State Hearing Decision 8/21/14, p.1.* Appellant's family members who received the gifts were required to pay that amount to Appellant for Appellant to be eligible for additional Medicaid coverage.

The parties also agree that the penalty period should be 27.21 months. This is based in part on the $180,814.41 returned to Appellant's account by the family members which leaves a balance of $163,891.47 still outstanding as an improperly gifted amount. *See Administrative Appeal Decision, 1/22/15, p. 2.* Appellant does not contest the 27.21 month length of the

Medicaid restricted period, the amount paid back, nor the final determination of the amount still owed from the improper transfer throughout the administrative hearing appeal process.

The $180,814.41 paid back to Appellant from April 2001 until April 2014 was used to pay for Appellant's nursing home care from month to month. Appellant's family members did not pay the entire improperly transferred amount back all at once. Appellant's family made payments to Appellant's account each month to cover monthly nursing home expenses. Appellant's family would deposit enough money into Appellant's account to cover her nursing home bill for that month. Appellant continued making these payments until April of 2014. The parties agree that $180,814.41 was paid back to Appellant until April 2014.

Appellee recalculated the restricted coverage period several times since the entire amount improperly transferred was a number of separate transfers over a period of time. This resulted in different lengths of restricted period being ordered each time a calculation was made with newly discovered amounts being added or subtracted. *See State Hearing Decision of 8/21/14, p.1.*

## LAW & ANALYSIS

"Medicaid is a cooperative federal-state program through which the federal government offers financial assistance to participating states that provide medical care to needy individuals." *Wood v. Tompkins* (C.A.6, 1994), 33 F.3d 600, 602. A participating state is required to develop reasonable standards for determining eligibility consistent with the act. Section 1396(a)(17), Title 42, U.S. Code. Ohio participates in the Medicaid program and has codified its eligibility requirements at R.C. 5111.01 et seq. See, also, former *Ohio Adm. Code 5101:1-39 et seq.*

A court of common pleas may affirm an administrative agency's determination if it is "supported by reliable, probative, and substantial evidence and is in accordance with law." *R.C.*

*119.12.* On judicial review, an administrative agency's findings of fact are presumed to be correct and must be deferred to by a reviewing court unless that court determines that the agency's findings are internally inconsistent or are otherwise unsupportable. *R.C. § 119.12.* All reviewing courts must give due deference to an administrative agency's interpretation of its own rules and regulations if such an interpretation is consistent with statutory law and the plain language of the rule itself. *R.C. § 119.12.*

The Court reviews Appellant's appeal in light of the evidentiary standard that the Appellee Agency must show by a preponderance of the evidence that its action or inaction was in accordance with the Ohio Administrative Code. *See OAC §5101:6-7-01(2010).* The Court reviews the matter to determine if there is substantial, probative and reliable evidence to support Appellee's decision.

As a result of it having been determined that there was an improper gift made to a family member(s) within the sixty month look back period of $344,705.88, Appellant was placed in a Medicaid restricted period calculated pursuant to OAC §5160:1-03-07(I). "Restricted Medicaid coverage means the period of time an individual is ineligible for nursing facility payments, a level of care in any institution equivalent to that of nursing facility services and home or community-based services * * *." Ohio Admin. Code 5101:1–39–07(B)(12). If it is determined that a restricted Medicaid coverage period applies, the restricted Medicaid coverage period must be calculated in accordance with Ohio Adm. Code 5101:1–39–07(J)(1).

The Appellee determined the restricted period from the date where Appellant would otherwise have been eligible for Medicaid services if not for the imposition of the restricted period. The Appellee originally determined this to be April 2011, one month after Appellant

entered into a long term care facility on March 7, 2011. See State Hearing Decision, 8/21/2014. The restricted period was to run fifty-seven months.

In the Appellee's final appeal decision of 1/22/15, Appellee determined that Appellant became eligible for Medicaid coverage in April 2014. As of April 2014, Appellant's family paid back $180,814.41 of improperly transferred funds back to Appellant which was in turn used to pay her monthly nursing home bills. The parties agree that the length of the restricted period should now be 27.21 months but do not agree when the restricted period should start or should have started.

Appellant also asserts Appellee has not demonstrated that the spend down limit of $1500 was calculated on a month to month basis. Appellant argues that there is insufficient evidence to show that Appellee made such calculations. Appellant additionally argues that the Appellee improperly shifted the burden of proof to Appellant denying a prior appeal based upon a lack of Appellant to produce bank records in support of its spend down argument. Appellant also asserts that it was the Appellee's burden and not Appellant's burden to calculate whether Appellant met the spend down amount each month. All these issues are interrelated so the Court addresses them together.

Appellee's position is that the restricted coverage period start date *should* be April 2014, but because the 8/21/14 State Hearing Decision references "April 2012" in its decision, then April 2012 should be the start date of the restricted period. Appellee's 1/22/15 hearing officer interpreted that comment to indicate the 8/21/14 hearing officer made the determination that the April 2012 was ordered.

'Patient liability' means the individual's financial obligation toward the medical cost of care." Ohio Adm. Code 5101:1–39–24(B)(22). The procedure for determining an individual's

patient liability is set forth in Ohio Adm. Code 5101:1–39–24(C)(2), which states: "The administrative agency must determine the individual's patient liability by utilizing the following procedure, in sequence, subsequent to notification of an appropriate level of care, and, if applicable, HCBS waiver agency approval * * *: "(a) Total all income, earned and unearned, of the individual, without applying any exemptions or disregards." Appellant entered the long term care facility (LTCF) on 3/7/2011 and became continually institutionalized. She was determined to be eligible for Medicaid on 4/2011 when enrolled. However, Appellee then completed a resources check and found the first of many improper transferred amounts by Appellant to Appellant's family members.

"Resource limit" is defined as the maximum amount *combined value of all resources* (Court's emphasis) an individual can have an ownership interest in and still qualify for Medicaid. For an individual, the resource limit is one thousand five hundred dollars ($1500). *OAC §5160:1-3-05 (2006).*

A final determination made at the end of 2013 found that Appellant had improperly gifted $344,705.88 within the sixty month lookback period after some transfers which were erroneously counted twice were credited. Ultimately, the parties represent that Appellant repaid $180,814.41 as of April 2014.

Appellant's Medicaid restricted coverage period started April of 2011. During the restricted period, Appellant was not eligible for LTCF assistance because she had adequate resources to pay for her care by virtue of counting her improperly transferred funds as a resource. Her family repaid the improperly transferred funds one month at time to cover her nursing home expenses. Therefore, while her $180,814.41 nursing home expenses were privately paid a month

at a time, Appellant was in a restricted coverage period as a result. This period of restricted coverage beginning April 2011 was in compliance with the administrative rules.

For improper transfers "* * *, the restricted Medicaid coverage period begins the later of the first day of the month during or after which assets were transferred for less than fair market value; or the date on which the individual is eligible for medical assistance would otherwise be receiving the terms care services in an LTCJ, under an HCBS waiver program, or under the PACE program, based upon an approved application for such care but for the application of the penalty period." *OAC §5160:1-3-07(I), (J), and (K)(2006).* Her restricted coverage period originally started April 2011.

Until the improperly transferred amount was paid back in full, the Court finds that there is substantial, reliable and probative evidence to conclude that outstanding balance of the improper transfer was countable as a resource on a month to month basis from April 2011 until April 2014. See *R.C. §5111.151(E)(1); OAC §5101:1–39–05(B)(10), (B)(11)(a), (C)(1), §5101:1–39–27.1; OAC §5160:1-3-07(I), (J), and (K)(2006); R.C. §5163.21.* The Court further finds that the Appellee correctly included the improperly transferred monies as countable resources for purposes of determine Medicaid eligibility relying, in part, upon *OAC §5160:1-3-05 (2006), OAC 5101:1–39–24(C)(2), OAC 5101:1–39–24(B)(22), OAC §5160:1-03-07(I). OAC 5101:1–39–07(B)(12), OAC 5101:1–39–07(J)(1).* The Court also finds that based upon the record, Appellant's restricted period ended April 2014 with the paying back of $180,814.41 improperly transferred funds.

However, Appellant argues that OAC §5160:1-3-08(M) should be interpreted in support of Appellant's position of an April 2011 restricted period start date since only a small portion of the total amount was transferred back to Appellant each month, and then only used to pay her

nursing home bills. As a result of paying these bills, Appellant was left with an amount in her account of under $1500 on a monthly basis. The Court does not agree.

OAC §5160:1-3-08(M) provides: "Receipt in cash, income in kind, or something of value in a particular month is income to the individual for that month. Any portion of the income which is retained by an individual into the next month becomes a resource." Taken by itself, this section seems to control and resolve the matter in favor of Appellant. However, it must be read along with with *OAC §5160:1-3-05 (2006)* which defines "resource limit." "Resource limit" means the maximum amount *combined value of all resources* (Court's emphasis) an individual can have an ownership interest in and still qualify for Medicaid. *OAC §5160:1-3-05.*

For an individual, the resource limit is one thousand five hundred dollars ($1500)." *OAC §5160:1-3-05 (2006).* Here, the family member(s) who received the $344,705.88 gift is (are) paying the amount back to Appellant pursuant to Appellee's finding that the amount was an improper gift. Therefore, the Court finds that the $344,705.88 is includable as Appellant's resource. Appellant tries to treat this $180,814.41 amount as the family member's money being paid for the benefit of the Appellant. However, the Court finds that the amount is actually Appellant's money being held by the family member and is being repaid to Appellant. This is due to the sixty month lookback period used for purposes of determining resources for calculating Appellant's Medicaid eligibility. In essence, the family members become trustees of the improperly transferred monies until those amounts are paid back to Appellant. Therefore, any portion of the $344,705.88 is includable as a resource for purposes of calculation of Medicaid coverage eligibility and the monthly spend down limit.

The Court finds that the cash in Appellant's account was only one resource. The monies that were improperly transferred were a source of income to her based upon the findings that

improper transfers had occurred. The money cannot be sheltered with family members to alter its status as improperly transferred funds. Further, the Court finds that the Appellee did calculate Appellant's resources month per month when it was crediting Appellant's account for the monies paid back for her nursing home care. The spreadsheet sets forth the monthly balance of the improper transfer monthly paybacks and monthly balances were received by the hearing officer and contained in the certified records to this Court. The hearing officer was permitted to consider this information along with testimony and other records admitted into the record to find, as the parties agree, that monthly payments were being made month to month on Appellant's behalf as a result of monies that Appellant was found to have improperly transferred. It is further consistent with all the evidence that a total of $180,814.14 was repaid in monthly increments from April 2011 to April 2014.

The Court finds that the improperly transferred money balances at the end of each month reveal the total resources that the Appellant had available as well as the amounts paid per month on Appellant's behalf. This with other information in the record is sufficient for Court to find that there was substantial, reliable, probative evidence that the transferred/gifted money to the family member(s) was an additional resource for calculating Medicaid eligibility purposes including the monthly spend down limit. Additionally, the entire improperly transferred amount cannot be ignored for purposes of calculating the Medicaid spend down amount or total availability of resources. See *R.C. § 5111.151(E)(1); OAC 5101:1–39–05(B)(10), (B)(11)(a), (C)(1), 5101:1–39–27.1; OAC §5160:1-3-07(I), (J), and (K)(2006); R.C. §5163.21.*

The Court also finds that pursuant to *OAC §5160:1-3-07,* Appellant remains in the restricted period until the improperly gifted funds are paid to the Appellant. When the amount was repaid then the Appellant could be relieved from the Medicaid restricted coverage period.

Until that time, the Court finds that Appellant was in the restricted coverage period. While there still remains a balance to be paid the restrictive period may be modified. However, the Court notes that this is discretionary since the word "may" is used. It is not required that a modification be made to the restricted period.

Neither party seems to take issue that Appellant was in a restricted Medicaid period from April 2011 until April 2014. The issue before the Court is whether a 27.21 month restricted period calculated based upon the $163,891.47 balance can or should be applied retroactively to the original April 2011 restricted period start date as Appellant requests. However, the Court finds that the restricted period should not be started on April 2011 based upon the particular facts before it. The Court finds that the restricted period terms should start April 1, 2014 but concludes that there is probative, credible and reliable evidence the State Appeal Hearing officer correctly found that April 1, 2012 should be the start date since Appellant cannot be placed in a worse position by the appeal decision.

Concerning the monthly calculation of resources, the Court agrees that "The rule requires the Agency to determine eligibility for each month in the restricted Medicaid coverage period and include the returned asset as an available resource unless the asset would have otherwise been considered an exempt asset." See State Hearing Decision 8/21/14, p.5. "Here the asset was not considered exempt." See State Hearing Decision 8/21/14, p.5. Therefore, the returned asset was counted as a resource and it appears that the Appellant would have been ineligible for Medicaid benefits as a result since her *available* resources were still well over $1500 due to improperly transferred monies still owed. The hearing officer properly considered that the money was being paid back on a monthly basis and properly concluded that it was only a portion

of Appellant's *total* remaining resources in spite of the account potentially being below the $1500 spend down limit. *OAC §5160:1-3-05.*

Additionally, Appellee testified that "Appellant's son re-conveyed monies to the Appellant each month from 4/1/2011 through 4/1/2014 in the total amount of $180,814.41 and then paid the nursing facility, which was used to pay for Appellant's care in the LTCF." State Hearing Decision 8/21/14, p.4. This is corroborated by the spreadsheet which was admitted and made part of the record setting forth the payments made month to month. The Appellee originally determined that the restricted period should run from 4/2011 through 12/2016 with a partial penalty for 1/2017. State Agency Hearing Decision 8/21/14, p. 4, para. 8. Again, Appellant is found to be properly found over-resourced from month to month. *OAC §5160:1-3-05 (2006).*

Therefore, the Court also finds that there is sufficient evidence that the Appellee did make monthly calculations of Appellant's resources for purposes of determining if she met the $1500 spend down limit. Appellee was crediting Appellant's account for the improperly gifted amount being repaid to Appellee each month. Therefore, Appellee was fully aware of Appellant's available resources on a monthly basis as there was an outstanding amount of improperly transferred funds required to be paid back. The 1/22/15 hearing officer properly reviewed the evidence in the record. Appellant was living in a restricted Medicaid coverage period, so she was not eligible for long term care facility Medicaid coverage until the improperly transferred amount was paid back in full. Again, the spreadsheet and other information in the record provides substantial, reliable and probative information that Applicant was over-resourced from April 2011 until April 2014.

Appellant also asserts that Appellant's monthly available resources were below $1500 each month. Appellant claims because a portion of the improperly transferred money was paid back to Appellant's account and then used immediately to pay the monthly nursing home bill, her balance was under $1500 at each monthly snapshot in time. As a result, Appellant argues that she should be considered Medicaid eligible from month to month because she met the $1500 spend down limit. This is interrelated to Appellant's argument that there is a lack of evidence to support a conclusion that Appellee made a monthly calculation of Appellant's resources.

However, the Court finds that there is sufficient evidence in the record showing Appellant received the improperly transferred gift in various amounts from April 2011 through April 2014 each month. The Court also finds that at the end of each month, Appellee made a monthly calculation as to Appellant's available resources. At a minimum, Appellee calculated the remaining balance of the improper gift that was outstanding. This amount made Appellant over-resourced for each month until the last of the $180,814.41 improper transfers was paid back to Appellant in April 2014 and therefore she remained in a restricted penalty period during that time. Therefore, a monthly calculation of resources was made.

The Court interprets Appellant's argument to be that only the "portion" of the monies returned to Appellant from which nursing home payments were made is Appellant's only available resource. However, the Court finds that the entire amount of $180,814.14 is available to Appellant and therefore countable as a resource since Appellee determined that Appellant improperly transferred those monies. Rather than consider breaking the trust, the Court defers to the determination that the monies need to be paid back to Appellant for her to be considered Medicaid eligible. For purposes of calculating resources relevant to the issues herein, the Court finds that there is probative, substantial and reliable evidence to find that the improperly

transferred amount is demonstrated to be an available resource for Appellant that places her over the monthly spend down limit until the improperly transferred amount is paid back.

Further, in a similar case, the 9th District Court of Appeals found that administrative rules specifically defining treatment of trust for determining Medicaid eligibility, not administrative rule providing general definition of "resource," applied when deciding whether principal of applicant's irrevocable trust was resource available to applicant that counted toward $1,500 resource limit concerning application for Medicaid nursing home benefits. *Estate of Gsellman v. Ohio Dept. of Job & Family Servs.* (Ohio App. 9 Dist., Summit, 04-11-2012) No. 25954, 2012-Ohio-1620, 2012 WL 1207419, unreported. See also, R.C. § 5111.151(E)(1); OAC 5101:1–39–05(B)(10), (B)(11)(a), (C)(1), 5101:1–39–27.1. In that case the court determined that the trust was a countable resource. The Court relies upon this case for guidance and in support of its determination that the trust resources are countable for purposes of a Medicaid computation.

However, even without guidance from *Estate of Gsellman v. Ohio Dept. of Job & Family Servs.*, this Court finds that when a person is determined to be in possession of monies that have been deemed to have remained Appellant's pursuant to the sixty month look-back period rule, those monies remain Appellant's. So for purposes of determining eligibility for Medicaid coverage, the Court finds that Appellant has access to these monies for purposes of a Medicaid resource calculation. The Court further finds that the family member given the money was required to pay that money back to Appellant for Appellant to be considered eligible for Medicaid services. There are numerous references in the decisions to the testimony of the parties to support the hearing officers' rulings concerning these issues including those aforementioned.

Therefore, the Court finds that there was substantial, probative and reliable evidence in the record to support the Court's determination that the improperly transferred funds were

countable as a resource and that the Appellee did calculate Appellant's resources for purposes of determining her Medicaid eligibility on a month to month basis.

The art of creative estate planning is not lost on the Court. However, to allow a person to avail themselves of Medicaid long term care facility benefits during a period where they are being penalized by being placed in a restricted period for having improperly transferred funds for purposes of determining eligibility for services is not appropriate. By the way of analogy, the Court likens it to a hockey player being placed in the penalty box for a violation of the game. Applying Appellant's argument, Appellant would still be able to take a penalty shot on goal even though the penalized player remains under penalty and in the penalty box. The Court does not see how that is possible under the circumstances since Appellant remains in the restrict Medicaid covered period while she is attempting to avail herself of full Medicaid benefits. Therefore, the Court finds there is substantial, probative and reliable evidence to finds that the Appellee made a monthly calculation of Appellant's resources as required by the administrative rules as well as properly considered the improperly transferred amounts as Appellant's resource on a month to month basis from April 2011 until April 2014.

The Court also notes that it does not appear that Appellant raised the potential lack of monthly calculation issue in prior hearings. The Court finds that Appellant waived this objection as to whether a monthly calculation was made by Appellee at the previous administrative hearings. Regardless, this Court finds that there is sufficient competent, reliable and probative evidence to support Appellee's 1/22/2015 decision. In part, the calculations showed that Appellant was over-resourced until the $180,814.41 amount of the improperly transferred gift was paid back as of April 2014 when a large lump sum payment was made. Therefore, Appellant's appeal on this issue is not well taken and is overruled.

The Court also finds that since the Appellant was over-resourced on a monthly basis based upon the calculations and since there is an outstanding amount of the improper transfer of funds of $163,891.47, the Court finds that there is substantial, reliable and probative evidence that Appellant remains over-resourced as of April 2014. Therefore, the Court finds it would not be proper to date the 27.21 month restricted period back to April 2011. To do so would allow to use her previously served restricted period to fulfill her 27.21 month penalty period. It would also allow her to become eligible for LTCF benefits earlier than originally projected under such a finding, and potentially allow her family to retain all or a portion of the $163,891.47 of the remaining improperly transferred funds. The Court believes this would thwart the purpose of the administrative rules which are designed to endure that only resource eligible individuals are permitted to avail themselves of such benefits. The Court again is drawn back to its hockey analogy.

The Court finds that the Appellant should not be allowed to take advantage of improperly transferring funds to avoid paying for her own care. Nor should she be permitted to take advantage of Medicaid benefits when she had improperly transferred money pursuant to the administrative rules during the restricted period.

Appellant also asserts that the burden of proof was improperly shifted to Appellant by Appellee. The Appellee made reference that Appellant did not provide any bank records to support its position that spend down was met. Appellant does not contest the facts submitted, but asserts that it is the Appellee that must demonstrate that the $1500 spend down limit was not met and failed to do so.

As previously discussed above, the Court finds that the Appellee did make monthly calculations when it determined on a monthly basis that Appellant was over-resourced from

April 2011 until April 2014 while $180,814.14 of improperly transferred funds were paid back so the Court believes Appellant's argument on this issue fails. Appellee did not challenge the fact that the Appellant's family was paying Appellant's nursing care facility bills on a monthly basis. In fact, Appellee was crediting Appellant the nursing home bill average rate of pay. And, since Appellant was over-resourced from April 2011 until April 2014, providing any additional bank records would not have altered her status of ineligibility as the Court has determined that she was over-resourced.

Additionally, the administrative rules provide that the burden can shift to the applicant for verification of income purposes. Under Section 5111.01.1(A) of the Ohio Revised Code, the General Assembly directed the state department of job and family services to "adopt rules establishing eligibility requirements for the Medicaid program." The rules, however, must be consistent with state and federal law. *Id.* Exercising its authority, the state department of job and family services adopted Rule 5101:1–39–05(C)(1), which provides that "[a]n individual is ineligible for medical assistance if he or she has an ownership interest in resources with an aggregate or total countable value greater than the resource limit." The resource limit for an individual is "one thousand five hundred dollars." Ohio Admin. Code 5101:1–39–05(B)(11)(a).

Ohio Adm. Code §5160:1-3-03.1(G)(1) provides: "The individual's statements of source and amount of income are subject to verification. At the time of application/reapplication, the individual and household member(s) whose income affects the individual, must be required to submit documents which verify *all sources of income*. If necessary, the administrative agency must obtain a signed release of information and contact other sources to verify income. (2) An individual's report of income is subject to verification when a review is conducted by the ODM quality assurance review section. (3) *The individual has the burden of verifying the sources and*

*amounts of income, and has the responsibility of reporting income changes to the administrative agency.* (4) When an individual claims to have no income at the time of application/reapplication, the administrative agency must review the application/reapplication for inconsistencies requiring resolution. *It is the individual's responsibility to support the claim of no income.* However, if verification is not available and the individual has cooperated in trying to obtain it, the administrative agency may process the case based on the individual's statement as long as there is no evidence to cast doubt on the income allegations * * * ." (Court's emphasis).

The Court finds that Appellant's application for Medicaid coverage is reconsidered each month based upon her repayment of outstanding improperly transferred funds. As stated above, the Court found that the Appellee did re-determine her eligibility each month in computing whether the improperly transferred funds were repaid. As they remain unpaid, she was Medicaid ineligible for being over resourced. Appellant could have presented additional evidence but chose not to do so. Additionally, Appellee is permitted to request verification of income.

Additionally, income is counted every month for determination of Medicaid eligibility. Ohio Adm. Code §5160:1-3-03.1 provides: * * * "(D) Income is counted on a monthly basis. (1) Gross income, prior to any deductions, exemptions or exclusions, *that can be reliably anticipated* is considered available in calculating countable income for a month * * * * (Court's emphasis). (E) Under certain circumstances, the amount of income which must be determined as available to an individual may be greater than an individual will receive or have for his own use.

In this case, Appellant has an amount of income which is greater than she will receive or have for her own use on a monthly basis. Ohio Adm. Code §5160:1-3-03.1(E). Further, pursuant to Ohio Adm. Code §5160:1-3-03.1 (E)(3), "Deductions due to a repayment of an overpayment, loan, or other debt must be considered as available income * * * *. In this case,

the Court considers repayment of the improperly transferred gift from the gift recipient family member to the Appellant as payment of a debt owed to the Appellant for purposes of the monthly computation for Medicaid coverage eligibility.

Therefore, under these facts the Court finds that the Appellee did calculate the monthly resources for purposes of determining spend down eligibility. This can be seen in the spreadsheet of calculations found in the Certified Records, dated 2/24/15 and filed 2/26/15, pp. 31-34. In this spreadsheet, the amounts set forth are consistent with Appellant's position that monies were paid back to Appellant's account as well as showing the remaining balance of improperly transferred funds month after month.

It is apparent that Appellant was not paid the entire improperly transferred amount all at once, in light of the $163,891.47 balance left to be paid back as of 4/1/2014. Appellant contends that this is insufficient evidence. However, monthly repayment calculations and credits were made part of the record. Additionally, Appellant has conceded that the amount paid back as of April 2014 was $180,814.41 and that there remains a balance of $163,891.47 that is still outstanding. Further, Appellant does not challenge the length of restricted period calculation of 27.21 months based upon the outstanding $163,891.47 balance. Therefore, the Court finds that the state appeal hearing officer could properly rely upon the figures contained in the spreadsheet which was submitted with the certified records to this Court as part of this appeal. Therefore, the Court relies in part upon the spreadsheet as well as the record in finding that Appellee did make calculations of Appellant's resources on a monthly basis.

Further, the records from page 40-46, titled "Individual Eligibility History," references "Dorothy Dowler," Appellant herein, and lists her "ELIG STAT," as either "PASS" or "FAIL" on a month to month basis. See Certified Records, dated 2/24/15, and filed 2/26/15. Further

records found on pages 48-85 make reference to "AG FAILED DELAYED SPEND-DOWN MED BUDGET" and lists "AG's NAME: D. DOWLER." See Certified Records, dated 2/24/15, and filed 2/26/15. This was in addition to testimony provided to the hearing officer. The Court finds such information to support its finding that there was sufficient evidence introduced to find that Appellee made monthly computations of resources regardless of information submitted by Appellant and that Appellant was over-resourced. Appellant produced some evidence, however the burden of proof was not improperly shifted to Appellant. Appellee could properly request verification of income from Appellant. Further, absent any records from Appellant, Appellee conducted a monthly calculation of resources relying upon the records it did have concerning improperly transferred amount.

Therefore, the Court finds that there is substantial, reliable and probative evidence to support that Appellee did not improperly shift the burden upon Appellant.

Appellant also appeals Appellee's determination that the starting date of the restricted period should be 4/1/2012 even though Appellee reasons that April 2014 should be the date of restricted coverage since this was the first month that Appellant was eligible for Medicaid coverage relying upon 5101:1-3-07. *See 1/22/15 Hearing Decision, p. 3.* However, Appellee concedes that the Appellee cannot place the Appellant in a worse position and decided that the restricted period should be 4/2012 based upon the 8/21/14 State hearing Decision. O.A.C. §5101:6-8-01. The Court reviews the 1/22/15 Appeal Decision to determine whether there is sufficient evidence to uphold its decision.

The 1/22/15 hearing officer believes that the Medicaid restricted period begins 4/2014, since Appellant is only eligible for Medicaid benefits as of that date which represents "the date of the last payment made of the improperly transferred sums." The Court finds that Applicant's

family made a payment of $23,775 in April 2014. With this amount, the Court finds that as of 4/2014, the total amount paid back to Appellee was $180,814.41 of Appellant's improperly transferred amount. The State's 1/22/15 Hearing Decision, Appellee reasons as follows: "Here the restricted coverage period began when Appellant was first eligible for Medicaid, which was April 2014, the month when the last of the assets were reconveyed. The period of ineligibly was calculated by using the amount of the assets returned or $163,891.47 divided by $6023 the private pay rate for a total of 27.21 months for the restricted period. The hearing decision refers to April 2014 as the last month when assets were returned and paid to the nursing facility. This was the month in which Appellant was eligible for Medicaid and therefore, this is when the restricted period should begin. The hearing decision, however later states that April 2012 is when the period should begin and finds a restricted period to a partial month of July 2015. Clearly, the hearing decision has internal inconsistencies." *See State Appeal Hearing Decision, 1/22/15, p. 3.*

However, the State Appeal Hearing officer concluded that although the 4/2014 date would be the appropriate date to start the restricted period, Appellant would be in a worse place than enforcing the prior State Hearing officer's decision from 8/21/14 that April 2012 should be the starting date of the restricted period. "Because this would place Appellant in a "worse position," we must therefore, affirm the state hearing decision." See State Appeals Hearing Decision, 1/22/15, p.3. Therefore, the Appeal Hearing Officer concludes that the start of the restricted period coverage date should be 4/2012. O.A.C. §5101:6-8-01.

The Court finds that the reasoning of the Appeal Hearing Officer is correct and the conclusion that the start of the Medicaid restricted period should begin April 2012 is supported by probative, reliable and substantial evidence in light of O.A.C. §5101:6-8-01. Therefore, the

Appellee's decision is affirmed on this issue. The Court finds substantial, probative and reliable evidence to support that the starting date of the restricted period should be April 1, 2012 based upon the 1/22/15 appeal hearing decision.

OAC §5160:1-3-07(M)(4) provides: "When only part of the asset or its equivalent value is returned, a restricted Medicaid coverage period can be modified but not eliminated." However, the Court finds that there is no authority for the Appellee to "toll" the restricted Medicaid coverage period. Absent any authority on the issue, the Court finds that it is improper for the Appellee to toll the restricted coverage period. *See Administrative Hearing Decision of 11/14/14.*

The Court finds that original restricted period was 57 months based upon $344,705.88 being improperly transferred by the Applicant. By way of paying back $180,814.14, Applicant improperly transferred amount has been reduced to $163,891.47. As a result, a portion of the 57 month restricted period has already been served during the time of paying back of $180,814.14 of improperly transferred funds. Currently, the 27.21 period represents the remaining restricted period based upon the remaining $163,891.47 that is outstanding. The parties agree that the penalty period for the remaining $163,891.47 is 27.21 months as Applicant made a payment of $23,775 in April 2014. The question of when should the restricted period start for the 27.21 months that remain due to the unpaid $163,891.47.

It is discretionary to modify the restricted period. OAC §5160:1-3-07(M)(4). Also, if the improper gift of money had been paid back immediately, the entire restricted coverage period could have been voided. *See OAC §5160:1-3-07(M)(3).* This indicates to the Court that the restricted period date is flexible and may be modified based upon the facts before it. OAC §5160:1-3-07(M)(4). The Court finds that there is competent, reliable and probative evidence

that the 27.21 months should begin April 1, 2012 based upon the Appellee last determination that the Applicant cannot be placed in a worse position by the Appellee's decision in her appeal hearing.

Appellant wishes the Court to start the 27.21 months of restricted period as of 4/2011. However, the Court finds that to do so would be improper. The Court finds that there is substantial, reliable and probative evidence to demonstrate that Appellant was operating in a restricted period during the entire time she was paying back improperly transferred funds from 4/2011 until 4/2014 at which time $180,814.14 was transferred back from Appellant's family to Appellant. To start the remaining 27.21 month restricted coverage period from 4/2011 would improperly allow Applicant to receive credit twice for the period of restricted coverage she previously served. To do so would essentially count the restricted period twice to Appellant's benefit and to allow her to serve approximately half of the original 57 month restricted period as a result. The Court finds that Appellant was properly serving a term of restricted coverage while the $180,814.14 was being repaid. However, the Court finds that the 27.21 months of restricted coverage for the restricted period is supported by reliable, probative and competent evidence.

Ultimately, the Court must review the evidence to determine if the state appeal hearing decision was based upon reliable, probative and credible evidence. The Court finds there although there is sufficient evidence set forth that although the beginning date should be April 2014, that the 1/22/15 Appeal Decision officer properly determined that it cannot place the Applicant in a worse situation than she was previously in by setting the beginning date further out that the Appellees 8/21/14 designation of April 2012. See. O.A.C. §5101:6-8-01. Therefore, the Court finds that there is reliable, probative and substantial evidence to find that beginning of

the 27.21 month restrictive period is April of 2012 which is the designation by the Appellee in the final appeal decision (See State Appeal Decision, 1/22/15).

The Court finds that there is reliable, probative and substantial evidence that the restricted period coverage beginning date should be 4/1/2012. The Court does find that under these unique circumstances Appellant's appeal on this issue is not well taken and is overruled.

## CONCLUSION

On judicial review, an administrative agency's findings of fact are presumed to be correct and must be deferred to by a reviewing court unless that court determines that the agency's findings are internally inconsistent or are otherwise unsupportable. *R.C. § 119.12.* All reviewing courts must give due deference to an administrative agency's interpretation of its own rules and regulations if such an interpretation is consistent with statutory law and the plain language of the rule itself. *R.C. § 119.12.*

The Court finds that there was reliable, substantial and probative evidence to support the Appellee's determinations: that Appellant's restricted period coverage should begin April 1, 2012; that Appellant was over-resourced from April 2011 through April 2014; that there was sufficient evidence that Appellee did calculate Appellant's monthly resources for determination of Medicaid eligibility with regard to Appellant's $1500 spend down limit; that the restricted period is 27.21 months in length; that the burden of proof was not improperly transferred to Appellant; that the amount of improperly transferred funds from April 2011 until April 2014 was $180,814.14 and was repaid as of April 2014; and $163,891.47 is Appellant's remaining amount of improperly transferred funds. Appellant's appeal on these issues is overruled. The Appellee's 1/22/15 Administrative Appeal Decision issued by the Ohio Department of Job and Family Services, Bureau of Hearings, on January 22, 2015 is hereby affirmed.

The Court finds that there was substantial, reliable, and probative evidence that Appellee did make a monthly calculation of Appellant's resources and also finds that there was substantial, reliable, and probative evidence that Appellee made monthly calculations regarding Appellant reaching the $1500 spend down amount. The Court overrules Appellant's appeal on these issues.

The Court also finds that there was substantial, reliable, and probative evidence that Appellee did not improperly shift a burden of proof to Appellant and overrules Appellant's appeal on this issue.

The Court also finds that Appellant's restricted coverage period runs for 27.21 months and that there is substantial, probative and reliable evidence to support same.

The Court further finds that Appellant's determination that the restricted coverage period for the 27.21 months should start 4/1/2011 is unsupported. The Court further finds that Appellees' determination that the restricted coverage period should start 4/1/2012 is supported by substantial, reliable, and probative evidence.

The Court also finds that there is a lack of substantial, probative and reliable evidence for the Appellee to "toll" the restricted Medicaid coverage period and therefore the restricted Medicaid period shall not be tolled.

Therefore, the Court orders that the Medicaid coverage period based upon the improper gifting and transfer of $163,891.47 shall begin April 1, 2012, and the Court additionally finds that there is substantial, reliable and probative evidence to support such a finding.

All issues raised by Appellant are not well taken and are hereby overruled. Appellee's January 22, 2015 Decision on Appeal is affirmed. The Court orders that Appellee shall

immediately take whatever action is necessary action to carry out this Court's findings and orders.

**This is a judgment or final order, which may be appealed. The Clerk, pursuant to Civ. R. 58 (B), shall serve notice of same on all parties who are not in default for failure to appear. Within three days after journalization of this entry, the Clerk is required to serve notice of the judgment pursuant to Civ. R. 5 (B).**

JOURNALIZED
AUG 21 2015
FINAL APPEALABLE ORDER

IT IS SO ORDERED.

Judge George P. McCarthy

cc: Brian C. Cook and Don H. Chapin, Chapin Elder Law, 6724 Perimeter Loop Rd., Unit 125, Dublin, OH 43017, for Appellant Dorothy Dowler

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