

In the
Supreme Court of Ohio

LORETTA PACK, : Case Nos. 06-1207
 : 06-1343
 :
 Plaintiff-Appellee, :
 :
 : On Appeal from the
 v. : Licking County
 : Court of Appeals,
 CHARLOTTE OSBORN, : Fifth Appellate District
 :
 :
 Defendant-Appellee, : Court of Appeals Case
 : No. 05 CA 83
 :
 LICKING COUNTY DEPARTMENT OF :
 JOB AND FAMILY SERVICES, :
 :
 :
 Defendant-Appellant. :

MERIT BRIEF OF *AMICUS CURIAE*
OHIO ATTORNEY GENERAL JIM PETRO
IN SUPPORT OF DEFENDANT-APPELLANT LICKING COUNTY DEPARTMENT OF
JOB AND FAMILY SERVICES

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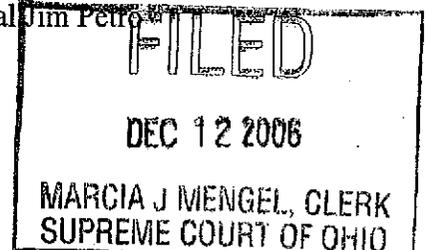
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INTRODUCTION

Administrative hearings and appeals are a critical part of many State laws and programs, including Medicaid, and the State has a great interest in maintaining the integrity of the administrative process. Thus, the Attorney General files this amicus here because that integrity is at stake. Specifically, the question here is whether issues that are firmly committed to an agency's administrative process, such as Medicaid eligibility, can be decided by declaratory judgment instead. The State urges the Court to hold that declaratory judgment may not be used to bypass an administrative agency process, such as the Medicaid hearing and appeal process at issue here. We also urge the Court to hold that issues of Medicaid eligibility must be decided by the law in effect when an applicant seeks benefits, even if a trust is involved; courts and agencies should not look back to the law in effect when a trust was created, nor to the law of any other long-ago time.

These issues arise because a party has tried to evade the administrative process, and because a party has tried to use old law rather than current law. Here, a Medicaid applicant, Appellee Charlotte Osborn, may or may not be eligible for Medicaid, because she is the beneficiary of a quarter-million-dollar trust. But the issue here is not whether she is eligible, but how that eligibility should be determined. The agencies responsible for deciding Medicaid eligibility, namely, the Licking County Department of Job and Family Services ("LCDJFS") and the statewide Ohio Department of Job and Family Services ("ODJFS"), were poised to address the issue of Osborn's trust and the ultimate issue of her eligibility for benefits. But the trustee of Osborn's trust, Appellee Loretta Pack, bypassed that process and filed a declaratory judgment lawsuit. In that suit, she asked a common pleas court to declare whether the trust should count as an asset of Osborn's in deciding her Medicaid eligibility. Pack also asked the court, in the alternative, to reform the trust so that it would not be counted.

The Court should reject Pack's attempt to bypass the administrative process, and it should hold that declaratory judgment is not available in cases such as this. Allowing such a declaratory-judgment to proceed would prevent the county department of job and family services from examining Osborn's trust, even though the relevant statute requires the county agency to do so. Such a suit not only violates the statutory commitment to the county and state agencies to decide such issues, but it also takes the issue away from the body that has the specialized expertise in the area. Further, such a suit also undermines the standard of review that should apply when a case goes from an administrative agency to the courts on appeal. For these reasons and others below, the Court should reject this effort to escape administrative review.

Notably, although this particular case deals with Medicaid beneficiary, the principle at issue could affect all of Ohio's administrative agencies, and the wrong outcome here could have devastating consequences for all those agencies. For example, all of Ohio's licensing boards (e.g., the Medical Board, Nursing Board, and the Ohio Department of Insurance, to name just a few) operate pursuant to statutes and rules that require licensees to first pursue licensing disputes through the administrative process and appeal any adverse administrative rulings through statutorily and/or regulatory prescribed appeals processes. Other regulatory agencies also have similar processes regarding administrative disputes and appeals. Together, Ohio's licensing and regulatory boards review over one million applications for benefits and/or license applications, each year. If the administrative process is undercut here, then surely others will seek to file declaratory-judgment cases asking courts to declare, for example, that they did not violate the standards of their professions, or that they are entitled to practice in Ohio, and so on. Such a result would be contrary to the General Assembly's intent in establishing administrative remedies, contrary to the intent of administrative agencies in drafting rules pursuant to enabling

legislation, and contrary to common sense. An individual seeking benefits from an administrative agency, whether it be a license or a government benefit, must be required to do so in accordance with the applicable statutory and regulatory framework. Furthermore, an individual seeking to challenge administrative action must be permitted to do so pursuant to specific, statutorily-created appeal rights.

In addition to protecting the integrity of the administrative process, the Court should hold that Medicaid law, or any similar State law, should be decided by using the law in effect when a person applies for benefits, or for a license, etc. Thus, here, when an individual who is the beneficiary of a trust applies for Medicaid, a county department of job and family services should determine the individual's Medicaid eligibility in accordance with the Medicaid eligibility laws in effect when the individual applied for Medicaid, not the Medicaid eligibility laws in effect when the trust was created. Otherwise, individuals will be able to unilaterally "grandfather in" old laws, and the State will be impaired in its ability to pass new laws to deal with new challenges.

For these reasons, the decision below should be reversed on both principles.

STATEMENT OF *AMICUS CURIAE* INTEREST

Ohio Attorney General Jim Petro represents the Ohio Department of Job and Family Services ("ODJFS"), which acts as the single state agency supervising the administration of Ohio's Medicaid program. 42 U.S.C. § 1396a(a)(5); R.C. 5111.01. With that responsibility comes the obligation to run an efficient and fair program for all Ohioans, both those receiving benefits and those supporting Medicaid through payment of taxes. The decision below greatly restricts ODJFS's ability to successfully administer the Medicaid program. Although the Licking County Department of Job and Family Services (the "County") is the party here and initially determined whether Charlotte Osborn was eligible for Medicaid, ODJFS has the final

administrative say on whether Osborn will receive benefits. Allowing the use of declaratory judgments to avoid ODJFS's administrative review process or collaterally attack ODJFS's eligibility decision could affect all benefit decisions made by ODJFS and other state agencies. This potential adverse impact on numerous administrative agencies represented by the Attorney General and the lower court's erroneous decision to apply outdated Medicaid eligibility rules gives the Attorney General an important interest in the outcome of this case.

STATEMENT OF THE CASE AND FACTS

This appeal involves two different cases. The first case (the "Medicaid Appeal") involves Charlotte Osborn's appeal from the County's denial of her application for Medicaid benefits. The second case involves Loretta Pack's declaratory judgment claim filed with the Licking County Common Pleas Court.

The facts of the Medicaid Appeal are as follows. On May 7, 2004, Charlotte Osborn applied for Medicaid benefits. State Hearing Decision Record, at 23-24. On June 2, 2004, the County denied her application because it found that assets of approximately \$270,000 in the Maebelle W. Osborn Trust (the "Trust") were available to Osborn. State Hearing Decision Record, at 1, 14, 23-24. Therefore, the County determined that Osborn's financial resources exceeded the Medicaid program's \$1,500 limit.¹ State Hearing Decision Record, at 14. Osborn requested an administrative hearing (referred to in this context as a "State Hearing") to challenge

¹ Medicaid was created to pay certain medical costs for those who cannot afford care themselves; it was not created to subsidize those who can afford their own care. See, e.g., *Ramey v. Reinertson* (10th Cir. 2001), 268 F.3d 955, 961, *quoting* House Committee on Energy and Commerce ("The Committee feels compelled to state the obvious. Medicaid is, and always has been, a program to provide basic health coverage to people who do not have sufficient income or resources to provide for themselves."). Thus, the rules for Medicaid eligibility involve an assessment of the applicant's available assets, and various deductions and exemptions are provided in the regulations. See Ohio Admin. Code 5101:1-39-05(B)(9).

the County's determination that she had too much money to receive Medicaid. State Hearing Decision Record, 13-15.

Osborn's State Hearing was scheduled for September 27, 2004. State Hearing Decision Record, at 1. The hearing notice specifically stated, "If you do not show up for your hearing, your case will be dismissed." *Id.* Five days before her State Hearing, Osborn sent an email to the Bureau of State Hearings, asking for her State Hearing to be re-scheduled until after the Licking County Common Pleas Court issued a decision in the Declaratory Case. State Hearing Decision Record, at 5.

The State Hearing Examiner did not agree to Osborn's request to delay the hearing. State Hearing Decision Record, at 2. Even though her request to continue the State Hearing had not been granted, neither Osborn nor her attorney appeared for the State Hearing. Administrative Appeal Decision at 1. Because neither Osborn nor her attorney appeared for the State Hearing, the hearing examiner found that Osborn had "abandoned" her State Hearing without good cause. State Hearing Decision Record, at 2. Osborn appealed from the State Hearing Decision and challenged the abandonment finding. Administrative Appeal Decision Record, at 5. The Administrative Appeal Decision affirmed the State Hearing Decision. *Id.* at 2. Osborn then appealed the Administrative Appeal Decision to the Licking County Common Pleas Court. At Osborn's request, the Licking County Common Pleas Court stayed Osborn's appeal pending the outcome of the Declaratory Case.

The dispute resulting in the Declaratory Case began when Loretta Pack, the trustee of Osborn's trust, filed a declaratory judgment action in the Licking County Common Pleas Court on the same day that Osborn applied for Medicaid benefits. The County was named in this case, but ODJFS was not. Pack asked the court to declare that the Trust assets were not available to

Osborn pursuant to R.C. 5111.151(G)(4) or, in the alternative, to reform the trust to comply with R.C. 5111.151(G)(4). That statute directs the County to examine trusts to determine whether trust assets are available to Medicaid applicants. R.C. 5111.151(C).

Osborn moved for summary judgment in the Declaratory Case. The common pleas court denied Osborn's motion, stating that the Trust assets are available to Osborn for purposes of determining Osborn's Medicaid eligibility.² On appeal, however, the Fifth District applied Medicaid eligibility law as it existed when the Trust was created in 1987. The appeals court held that the Trust assets are not available to Osborn, and should not have been counted when determining whether Osborn had over \$1,500 in resources. *Pack v. Osborn* (5th Dist. 2006), 2006 Ohio 2253 ¶28. The Fifth District stated that *Ohio Citizens Bank v. Mills* (1989), 45 Ohio St. 3d 153, required it to apply Medicaid eligibility law as it existed in 1987 to determine whether the Trust assets are available to Osborn for purposes of determining Osborn's Medicaid eligibility. *Pack*, 2005 Ohio 2253 at ¶¶27-28.

ARGUMENT

Amicus Curiae Attorney General's Proposition of Law No. 1:

Courts have no jurisdiction to review agency actions or declaratory judgment suits challenging those agency actions, except as provided by special statutory proceedings established to govern administrative appeals.

- A. Declaratory judgment should not be used to allow individuals to bypass special statutory proceedings established specifically to deal with administrative adjudications and appeals.**

The Court should reject Pack's and Osborn's attempt to use declaratory judgment to determine Osborn's eligibility for Medicaid. Allowing such a use of the declaratory judgment procedure would allow all Medicaid applicants to bypass the special statutory proceedings set up

to determine their Medicaid eligibility. As stated above, Medicaid applicants must have less than \$1,500 in “resources” in order to be eligible for Medicaid. In order to determine whether assets in a trust count toward this \$1,500 resource limit, county departments of job and family services must examine the trust and determine whether the assets in the trust are countable resources. R.C. 5111.151(C); Ohio Admin. Code 5101:1-39-27.1(A).

In this case, the County examined the Trust and determined that the Trust assets should be counted when determining whether Osborn had more than \$1,500, for purposes of Medicaid eligibility. Osborn disagreed with this determination, and requested a state hearing. Osborn’s state hearing request was proper pursuant to 5101.35(B) (“an appellant who appeals under federal or state law a decision or order of an agency administering a family services program shall, at the appellant’s request, be granted a state hearing by the department of job and family services.”).

However, before the County had even had a chance to examine the Trust, Pack filed the complaint in the Declaratory Case, thus circumventing the County’s administrative review of the Trust. Then, the Licking County Common Pleas Court, in the Declaratory Case, determined that the Trust assets should not be counted toward the Medicaid resource limit of \$1,500.

Lower courts have used a variety of legal doctrines to prevent individuals from making this kind of end-run around the administrative process. Some courts have dismissed cases filed in common pleas courts by holding that administrative tribunals have primary jurisdiction over such cases. See, e.g., *State ex rel. Gelesh v. State Med. Bd. of Ohio* (Franklin Co. C.P., Sept. 26, 2006), Case No. 05 CVH 12-13735, at 4 (attached as Exhibit 1); *In re Ohio Dept. of Agriculture*

² The County raised failure to exhaust administrative remedies as an affirmative defense in its answer to Pack’s complaint and asked the appeals court to reconsider on the grounds that declaratory judgments cannot be used to challenge administrative decisions.

Subpoenas (Darke Co. C.P., Sept. 7, 2006), Case No. 06-CV-63231, at 5 (attached as Exhibit 2). Others have dismissed as unripe cases filed in common pleas court before an agency has rendered an adjudication. See, e.g., *Johnson v. Ferguson-Ramos*, 2005 Ohio App. Lexis, 2005-Ohio-3280, ¶¶22-27. Still others have dismissed such cases for failure to exhaust administrative remedies. See, e.g., *Estate of Bundy v. Lucas Dept. of Job & Family Servs.* (Lucas Co. C.P., Nov. 23, 2005), Case No. 05-2354, at 6 (attached as Exhibit 3); *Morris v. Morris* (2nd Dist.), 2004 Ohio App. Lexis 5514, 2004-Ohio-6059, at ¶47.

Though the varying approaches discussed above all have merit, the best approach to resolve this case is to hold that individuals cannot file declaratory judgments actions to bypass special statutory proceedings, as the Court and several lower courts have held in other contexts. See *State ex rel. Albright v. Court of Common Pleas of Delaware County* (1991), 60 Ohio St. 3d 40, 42; *Mack v. Ohio State Dental Bd.* (10th Dist. 2001), 2001 Ohio App. Lexis 1513, at *7; *Dayton Street Transit Co. v. Dayton Power & Light Co.* (2nd Dist. 1937), 57 Ohio App. 299, 305-306; *State ex rel. Iris Sales Co., v. Voinovich* (8th Dist. 1975), 43 Ohio App. 2d 18, 19; *Wagner v. Krouse* (6th Dist. 1983), 7 Ohio App. 3d 378, 380; *Beasley v. City of East Cleveland* (8th Dist. 1984), 20 Ohio App. 3d 370, 373; *Arbor Health Care Co. v. Jackson* (10th Dist. 1987), 39 Ohio App. 3d 183, 186.

The doctrines of primary jurisdiction, ripeness, and failure to exhaust administrative remedies provide less satisfactory solutions, because these doctrines do not recognize that ODJFS has *exclusive* jurisdiction over Medicaid eligibility decisions. That is, such doctrines imply that declaratory relief *could* be available after the administrative route is exhausted, or when the claim is ripe, etc. Thus, these doctrines contain exceptions that future plaintiffs might use to circumvent the administrative hearing and review process. For example, the ripeness

doctrine implies that the court hearing the dispute might have had the power to do so, if the dispute had been brought to the court at a different time. See *Regional Rail Reorganization Act Cases* (1974), 419 U.S. 102, 140 (describing ripeness doctrine as “peculiarly a question of timing”); *State ex rel. Elyria Foundry Co. v. Industrial Comm’n of Ohio* (1998), 82 Ohio St. 3d 88, 89 (same). In cases like this one, however, the issue is not timing, but jurisdiction. Neither the Licking County Common Pleas Court nor the Fifth District should have exercised jurisdiction over Pack’s declaratory judgment action at *any* time. The doctrine of primary jurisdiction requires courts to engage in a balancing test and independently determine whether abstention is appropriate on a case-by-case basis. See *United States v. Haun* (6th Cir. 1997), 124 F.3d 745, 750; *United States v. Philadelphia Nat’l Bank* (1963), 374 U.S. 321, 353; *In re St. Mary Hospital* (Bankr. E.D. Pa. 1991), 125 B.R. 422, 430, citing *Baltimore Bank for Coops. v. Farmers Cheese Corp.* (3rd Cir. 1978), 583 F.2d 104, 108. The doctrine of exhaustion of administrative remedies does not fully prevent circumvention of the administrative process because it is subject to several exceptions. See *Jones v. Village of Chagrin Falls*, 77 Ohio St. 3d 456, 462, 1997-Ohio-253 (failure to exhaust administrative remedies is an affirmative defense subject to waiver); *Kaufman v. Newburgh Heights* (1971), 26 Ohio St. 2d 217, 220 (permitting declaratory judgment action where administrative board lacked authority to grant requested relief); *Karches v. City of Cincinnati* (1988), 38 Ohio St. 3d 12, 15-16 (noting that declaratory judgment action challenging constitutionality of ordinance is independent from administrative proceedings); *Burt Realty Corp. v. City of Columbus* (1970), 21 Ohio St. 2d 265, 268 (administrative exhaustion unnecessary for extraordinary remedy of mandamus); *Herrick v. Kosydar* (1975), 44 Ohio St. 2d 128, 130 (administrative proceeding is futile prerequisite where

sole issue is statute's constitutionality). None of the recognized exceptions allow circumvention of the administrative process in this case.

In Pack's memorandum in opposition to jurisdiction, Pack attempted to distinguish this case from other cases prohibiting individuals from circumventing special statutory proceedings or collaterally attacking administrative adjudications, but Pack's purported distinctions fail. First, Pack argued that this case does not involve an attempt to circumvent special statutory proceedings because Osborn filed the Medicaid Appeal and a different party, Pack, filed the Declaratory Case. Appellee's Memorandum in Opposition to Jurisdiction, at 7. But Pack offers no good reason *why* an individual should be able to evade administrative agency review simply because someone else files a declaratory judgment action that the individual would not have been able to file herself. To hold otherwise would allow individuals to remove themselves from the jurisdiction of administrative agencies simply by initiating litigation through a proxy. Further, even though Pack filed the Declaratory Case, Pack asked the court to determine whether the Trust assets should be counted as asset *available to Osborn* pursuant to R.C. 5111.151(G)(4)(a), or, in the alternative, to reform the Trust so that it complied with R.C. 5111.151(G)(4)(a). Complaint, ¶¶20, 23. Therefore, even though Pack filed the Complaint, she was seeking a declaration of Osborn's rights—not her own.

Pack's other purported distinction—namely, that the Declaratory Case does not “undermine or replace the administrative process”—also fails. See Pack's Memorandum in Opposition to Jurisdiction, at 7. The plain language of R.C. 5111.151(C) and Ohio Admin. Code 5101:1-39-27.1(A) requires *county departments of job and family services* to determine whether trust assets should be counted when determining an individual's Medicaid ability. Medicaid applicants can challenge a county's decision regarding the availability of trust assets through the administrative

hearing and appeal process. R.C. 5101.35(B) and (C). Such administrative reviews are governed by lengthy rules found at Ohio Admin. Code 5101:6-1, et seq., through 5101:6-9, et seq. See R.C. 5101.35(F). Further appeals are governed by R.C. 119.12 and 5101.35(E). By filing the Declaratory Case before the County had a chance to review the Trust, Pack attempted to circumvent the entire administrative review and appeal process and prevent ODJFS from examining the Trust as it is required to do pursuant to R.C. 5111.151(C) and Ohio Admin. Code 5101:1-39-27.1. This completely undermines and replaces the administrative review process. Allowing individuals to avoid agency review and have their rights determined by courts prevents agencies from exercising their particular expertise regarding the interpretation of administrative rules (rules that are often drafted by those agencies). This bypass also replaces the agency's hearing and appeal procedures with those of the forum in which the individual files the declaratory judgment or other action. This encourages forum shopping, and it creates the possibility of conflicting judgments in administrative hearings or appeals and judicial actions. The situation is particularly problematic in this case because Pack did not even join ODJFS in the Declaratory Case. If the County Prosecutor had not notified ODJFS of the Declaratory Case, Osborn could have evaded ODJFS's review entirely and ODJFS could have been adversely affected³ by an declaratory judgment without ever having received notice or an opportunity to be heard.

B. Allowing declaratory judgment in cases such as this would allow individuals to collaterally attack administrative adjudications.

Individuals have no inherent right to appeal or seek review of agency adjudications. *Cooke v. Kinney* (1981), 65 Ohio St. 2d 7, 8. The right to appeal an agency adjudication is purely

³ The Fifth District's opinion adversely affects ODJFS because ODJFS will pay for Osborn's Medicaid-covered health care services if she is ultimately found eligible to receive Medicaid benefits contrary to the eligibility rules.

statutory. *Id.* Therefore, would-be appellants must strictly comply with statutorily prescribed appeal provisions in order to perfect their appeals. *Id.*; *Holmes v. Union Gospel Press* (1980), 64 Ohio St. 2d 187, 188.

In this case, Osborn could have appealed the County's determination that the \$270,000 in the Trust was available to her only by requesting a State Hearing, appealing from the State Hearing Decision through an ODJFS Administrative Appeal, and appealing from the Administrative Appeal Decision to the Licking County Common Pleas Court pursuant to R.C. 119.12 and 5101.35(E). R.C. 119.12 & 5101.35; Ohio Admin. Code 5101:6-3-01, 5101:6-8-01(A), 5101:6-9-01. However, because Osborn failed to appear for her State Hearing, the only issue that the common pleas court could have reviewed was whether the Administrative Appeal Decision upholding the finding of abandonment was supported by reliable, probative, and substantial evidence and was in accordance with law. See *Our Place, Inc. v. Ohio Liquor Control Comm'n* (1992), 63 Ohio St. 3d 570, 571; *Rossiter v. State Med. Bd.* (10th Dist. 2004), 155 Ohio App. 3d 689, 692.

Therefore, when the Fifth District reviewed the Declaratory Case, the Fifth District's opinion became, in effect, an improper collateral attack on an Administrative Appeal Decision. It was improper not only because it allowed Pack to use impermissible means to challenge the County's determination (declaratory judgment vs. administrative appeal), but also because it allowed Pack to raise issues that Osborn was precluded from raising because she failed to attend her State Hearing.

At least one lower court has recognized that, regardless of how a claim is brought, if the substance of the claim challenges a Medicaid eligibility determination, the claim must be brought

through the administrative appeal process outlined above. See *George v. Ohio Dept. of Human Servs.* (10th Dist.), 2005 Ohio App. Lexis 2191, 2005-Ohio-2292, ¶¶31-35, *discretionary appeal denied*, 106 Ohio St. 3d 1545. In *George*, an individual whose Medicaid application had been denied sued ODJFS in the Court of Claims, seeking money damages because ODJFS's allegedly improper denial of her Medicaid application caused her to pay for her own nursing care. *Id.* at ¶2. The Tenth District dismissed the complaint, stating that, although the complaint was crafted as an action for damages, the plaintiffs' action was in reality an appeal of ODJFS's Medicaid eligibility determination, which could be challenged only through the "process available to plaintiffs to dispute the validity of [ODJFS's] eligibility determinations." *Id.* at ¶31, 34.

C. The Fifth District improperly reviewed an issue within ODJFS's exclusive authority.

The Fifth District's approach causes yet another problem, which is particular to the Medicaid arena. Federal Medicaid laws require the State of Ohio to designate a single state agency to administer and supervise the administration of the Medicaid program in the state. See 42 U.S.C. §1396a(a)(5). Ohio has designated ODJFS as the single state agency. R.C. 5111.01. As such, ODJFS may not delegate the responsibility to make Medicaid eligibility determinations to entities other than "local agencies" administering the State Medicaid plan. 42 U.S.C. § 1396a(a)(5); 42 C.F.R. 431.10(e). County departments of job and family services are the local agencies administering the State Medicaid plan. R.C. 329.04. Therefore, county departments of job and family services have the exclusive authority to make initial Medicaid financial eligibility determinations. By exercising jurisdiction over Pack's declaratory judgment regarding the effect of the Trust upon Osborn's Medicaid eligibility, the Fifth District improperly exercised jurisdiction over a Medicaid eligibility issue that is expressly reserved to ODJFS and county departments of job and family services, in violation of R.C. 5111.151(C), Ohio Admin. Code 5101:1-39-27.1, and 42 U.S.C. § 1396a(a)(5).

Amicus Curiae Attorney General's Proposition of Law No. 2:

An individual's Medicaid eligibility must be determined in accordance with the laws in effect when the application is filed.

The Fifth District erred in saying that *Ohio Citizens Bank*, 45 Ohio St. 3d 153, required it to apply 1987 Medicaid eligibility laws to decide whether Trust assets were available to Osborn for purposes of determining Osborn's Medicaid eligibility. See *Pack*, 2006-Ohio-2253 at ¶¶27-28. This is wrong because *Ohio Citizens Bank* is irrelevant to the issue of Medicaid eligibility.

The facts of *Ohio Citizens Bank* show the difference. In 1944, Charles Breyman created a trust that distributed assets to his "living grandchildren and to the living children of each deceased grandchild." *Ohio Citizens Bank*, 45 Ohio St. 3d at 153. In 1985, the trustee of the Breyman trust sued to determine who were beneficiaries of the trust. *Id.* The issue was whether the language in the Breyman trust directing the distribution of assets to "living children of each deceased grandchild" intended to distribute assets to an adopted child. *Id.* The Sixth District held that it should apply the law in effect when the Breyman trustee brought the lawsuit to determine Mr. Breyman's intent. *Id.* This Court reversed and held provisions of the trust should be governed by the law existing at the time of the trust's creation, absent a contrary intent within the instrument itself. *Ohio Citizens Bank*, 45 Ohio St. 3d at 153.

The Court's holding in *Ohio Citizens Bank* does not apply here because the issue in that case was how the provisions of an instrument should be construed, whereas the issue in this case is how an instrument affects an individual's Medicaid eligibility. The first issue concerns a private dispute over how a trust is managed, while the second concerns a right to government benefits. The first is a matter of a donor's intent, which was framed in the context of a certain moment in time. The second reflects a public policy decision, and the legislature and agencies constantly revise policy rules to reflect current needs.

If the Fifth District had been able to properly exercise jurisdiction over this case (which it could not have done, as explained above), it may have been required to apply 1987 law to determine the intent of the Trust's grantor or determine the rights of various beneficiaries of the trust. However, that determination cannot resolve the issue of whether Osborn is eligible for Medicaid. In order to determine whether Osborn is eligible for Medicaid, the County and/or ODJFS must apply Medicaid eligibility laws as they existed at the time Osborn applied for Medicaid. See *Prior v. Ohio Dept. of Human Servs.* (10th Dist. 1997), 123 Ohio App. 3d., 381, 383 n.1; *Martin v. Ohio Dept. of Human Servs.* (2nd Dist. 1998), 130 Ohio App. 3d 512, 523-24; *Metz v. Ohio Dept. of Human Servs.* (6th Dist. 2001), 145 Ohio App. 3d 304, 315; *Miller v. Ohio Dept. of Human Servs.* (8th Dist. 1995), 105 Ohio App. 3d 539, 543.

Furthermore, Medicaid eligibility decisions cannot be made by applying common law. Medicaid eligibility decisions must be made in accordance with federal statutes, state laws, state administrative rules, and Ohio's state Medicaid plan, as approved by the federal Centers for Medicare and Medicaid Services ("CMS"). R.C. 5111.01 – 5111.191 (describing Medicaid eligibility criteria); Ohio Admin. Code 5101:1-38, et seq., through 5101:1-39, et seq. (same); *Antrican v. Odom* (4th Cir. 2002), 290 F.3d 178, 187 (discussing need to comply with state Medicaid plan approved by CMS).

Applying prior Medicaid eligibility laws to current Medicaid applications could easily lead to absurd results. For example, if an individual sued for a declaration of his Medicaid eligibility based on a trust established before 1965, the Fifth District would have ODJFS apply Medicaid eligibility laws as they existed before 1965. This would be impossible, however, as the Medicaid program did not exist until 1965. *Pharm. Research & Mfrs. of Am. v. Walsh* (2003), 538 U.S. 644, 650.

Also, applying former Medicaid eligibility laws would prevent Medicaid beneficiaries from participating in modern Medicaid programs, and would also allow Medicaid beneficiaries to participate in Medicaid programs that no longer exist. For example, in 2003, Ohio expanded the scope of Medicaid benefits by creating a new type of benefit referred to as a “Level One Waiver.” See Ohio Admin. Code 5101:3-42-01(A) (2005) (attached as Exhibit 4). If ODJFS were to apply Medicaid eligibility laws in effect before 2003 to an individual’s Medicaid application today, then it would have to deny Level One Waiver services to that individual, because there were no eligibility rules for the Level One Waiver services before 2003. Conversely, in 1991, Ohio terminated a Medicaid program providing disability assistance benefits. See *Daugherty v. Wallace* (2nd Dist. 1993), 87 Ohio App. 3d 228, 230-231. If ODJFS were to apply Medicaid eligibility laws as they existed before 1991, then ODJFS would have to provide individuals benefits pursuant to a now-defunct program, because they would have been eligible to receive such benefits pursuant to pre-1990 Medicaid eligibility laws. The Community Alternative Funding System (commonly referred to as CAFS) is example of Medicaid benefit program that was recently terminated. See 2005 H.B. 66, section 206.66.78, effective July 1, 2005.

The best way to prevent these and other problems is for the Court to hold that an individual’s eligibility for benefits is determined in accordance with the law governing benefits eligibility when he applies.

CONCLUSION

For the above reasons, this Court should reverse the Fifth District's decision and adopt the propositions of law stated above.

Respectfully submitted,

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CERTIFICATE OF SERVICE

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IN THE COURT OF COMMON PLEAS, FRANKLIN COUNTY, OHIO
CIVIL DIVISION

STATE OF OHIO, ex rel.,
GARY CHARLES GELESH, D.O.,

Relator,

v.

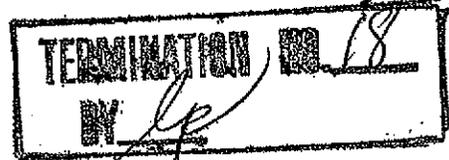
THE STATE MEDICAL BOARD OF
OHIO,

Respondent.

FINAL APPEALABLE ORDER

CASE NO. 05CVH-12-13735

JUDGE FRYE



JOURNAL ENTRY
(Granting Motion to Dismiss filed Dec. 21, 2005)
and
FINAL JUDGMENT

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COMMON PLEAS COURT
FRANKLIN CO. OHIO
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CLERK OF COURTS

The "Joint Complaint for Declaratory and Injunctive Relief, and Petition for Writ of Mandamus" was filed in this case in December 2005. Plaintiff/Relator is Gary Charles Gelesh, D.O., of Akron. Dr. Gelesh works in the field of emergency medicine and holds a license from the Medical Board. In May 2005 it is alleged that he was given written notice that the Medical Board intends to hold a hearing to determine whether to sanction him, and that he was entitled to the procedural protections in Chapter 119 of the Revised Code. The court understands from subsequent filings in this case that his administrative hearing is now scheduled to occur between October 16 – 20, 2006.

The substance of the inquiry by the Medical Board is treatment given by Dr. Gelesh to an 88 year-old patient in February 2002 in the emergency department at Akron General Medical Center. Apparently the patient was given a drug under the order of Dr. Gelesh which resulted in respiratory arrest a short time later. Paragraph 3 of the doctor's complaint in this court reflects, moreover, that the Medical Board initiated its inquiry only after reviewing a "deposition" in which Dr. Gelesh testified about the circumstances of his patient care.

HEALTH & HUMAN

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SERVICES SECTION

Paragraphs 4-6 of the complaint assert that “[u]nder the facts allowed by the Board in its Notice, Dr. Gelesh’s care of Patient 1 meets the definition of ‘comfort care’ under the Ohio Revised Code” and that the Code provides him “statutory immunity from professional disciplinary action.” R.C. §2133.11(D). Because the notice from the Board failed to allege that the doctor’s treatment was “outside the scope of his authority as Patient 1’s physician” and did not allege that “Dr. Gelesh failed to act in good faith when providing comfort care to Patient 1” (complaint paragraph 8) it is urged that this court find he has statutory immunity from professional disciplinary action as a matter of Ohio law. A Writ of Mandamus also is sought because the Medical Board “has a clear legal duty *** not to discipline a physician for providing comfort care.”

The Medical Board has broad authority, and administratively the primary jurisdiction over the medical profession. *E.g., Ohio State Medical Bd. v. Miller* (1989), 44 Ohio St.3d 136, 141. The Board has not yet made any decision which interferes with the ability of Dr. Gelesh to continue to practice medicine. To the contrary, it has only indicated that a hearing is appropriate, after providing the doctor with ample advance notice. Under this circumstance, injunctive relief is not appropriate. “Courts should take ‘particular caution * * * in granting injunctions, especially in cases affecting a public interest where the court is asked to interfere with or suspend the operation of important works or control the action of another department of government.’ *Leaseway Distrib. Centers, Inc. v. Dept. of Adm. Serv.* (1988), 49 Ohio App.3d 99, 106, 550 N.E.2d 955, 962; *Dandino v. Hoover* (1994), 70 Ohio St.3d 506, 639 N.E.2d 767. The issue whether to grant or deny an injunction is a matter solely within the discretion of the trial court ***” *Danis Clarkco Landfill Co. v. Clark Co. Solid Waste Mgt. Dist.* (1995), 73 Ohio St.3d 590, 604.

Although denying the injunction, the court will address the primary legal argument advanced which is that the Medical Board does not have legal authority to proceed because of the “immunity” language used in R.C. §2333.11. Dr. Gelesh suggests there must first be some initial determination that he is not entitled to immunity before any hearing can be held which, in turn, requires a finding that he was not acting in good faith, or was acting outside the scope of his authority.

Otherwise, he argues, he is entitled to statutory immunity for the care given to Patient 1 in 2002. In other words, he asks this court to find facts about his professional conduct and, based upon the court's findings, to block the administrative hearing.

Under certain circumstances immunity is available from any "professional disciplinary action." R.C. § 2133.11(A)(6). Ordinarily, a legal "immunity" (as it is expressly called in subsection (D) of the statute) is put in place to block legal proceedings at the outset, in order to avoid putting someone through pretrial discovery or any evidentiary hearing process. Merely being forced to participate in the legal process is thought to trigger public costs, and personal emotional and financial harms justifying a complete bar of "immunity" - in some circumstances. Yet, even true immunities are not always absolute or immediately available to block a hearing. *See, Will v. Hallock* (2006), ___ U.S. ___, 126 S.Ct. 952, 163 L.Ed.2d 836, 2006 U.S. App. LEXIS 911, discussing situations in which immunities can, and cannot, be protected through interlocutory appeals under the collateral order doctrine in federal law. Of course the well-known immunities like those given to a judge are usually fairly obviously applicable. Proceedings to stop lawsuits covered by such immunities can fairly readily be triggered, and cases are stopped at the pleadings stage or shortly thereafter. Judicial immunity, for instance, normally requires only a modest showing - that the act was done within the broad jurisdiction of office - and that is enough to stop a suit against a judge cold in its tracks. *E.g., Stern v. Mascio* (C.A. 6, 2001), 262 F.3d 600.

Although termed an "immunity" in the statute at issue here, the General Assembly did not set out any specific procedural mechanism to protect those, like Dr. Gelesh, from being required to participate in administrative hearings before the Medical Board. More importantly, this statute affords immunity only in certain fact-specific situations. That, in turn, requires an examination of the entire scope of patient care to determine if "immunity" actually applies. In other words this immunity is available only in specific factual circumstances and is not triggered by judicial office or some other readily observable status or criteria that can be determined without testimony or other case-specific evidence.

Because no hearing has to date been held in Dr. Gelesh's case, all relevant facts are not yet developed. It is impossible to say whether "immunity" in R.C. § 2133.11 actually applies to plaintiff/relator. Therefore, someone has to make the factual determinations relative to the "immunity" here placed in question. Dr. Gelesh would entrust that role to this court. Because the Medical Board otherwise has plenary jurisdiction and, ordinarily, conducts all evidentiary hearings addressed to the professional conduct of those within its licensing authority, the most logical reading of R.C. §2311.11 is that the Medical Board should in the first instance make all factual findings relative to conduct by Dr. Gelesh, including whether "immunity" is legally available to him.

Plaintiff also appears to assert that the Board's notice of hearing did not specifically allege that he acted in bad faith, or outside his authority with this patient. That was not a fatal misstep – assuming it was a mistake at all – since at most it was purely a procedural matter. Moreover, the court doubts that the Board has the obligation to assert or prove those questions of fact. Ordinarily an immunity predicated upon a question like "good faith" is considered an affirmative defense. The burden of asserting and proving an affirmative defense falls upon the party relying upon it, and need not be anticipated in advance by the other side. Beyond that, of course, the strict pleading rules applicable in a criminal context are not required on the civil side of the aisle, particularly within the relative informality normally attendant to administrative hearings which is thought to save everyone involved unnecessary cost and delay. The Board may conclude for its own reasons that the notice of hearing in this case ought to have been more complete and alleged other facts relative to R.C. § 2133.11, or that proceedings before it should in the future be handled differently. Those are concerns for the Board and Dr. Gelesh to thrash out at the administrative hearing. However, in this court's view, there was no obligation for the Board to do more than it did in this particular case such that this court would have any right to interfere with the impending hearing.

It goes without saying that once the Medical Board decides this case Dr. Gelesh will have a limited right to judicial review under R.C. § 119.12. Any errors by the Board prejudicial to the rights of Dr. Gelesh can be reviewed at that time.

For these reasons, the Court finds and determines that the administrative hearing noticed by the Medical Board to address Dr. Gelesh's professional conduct must be allowed to proceed. The Board should, in the first instance, apply all relevant provisions of Ohio law (consistent with its obligation in any case), and in the first instance determine if R.C. § 2133.11 has any relevance based upon factual findings made from evidence adduced before the Board. The "immunity" of Dr. Gelesh argued under R.C. § 2133.11 is not appropriately determined, in the first instance, by this court.

Dr. Gelesh has no clear right to relief in mandamus. Instead, he has a plain and adequate remedy in the ordinary course of the law. The request for a Writ is, therefore, **DENIED**. *E.g. State Ex. rel. Pressley v. Indus. Comm.* (1967), 11 Ohio St.2d 141, syllabus paragraph 3.

Accordingly, all of the relief sought by plaintiff/relator is Denied.

FINAL JUDGMENT

For the reasons stated in the decision set forth above, this case is dismissed at plaintiff/relator's costs.

***** THIS IS A FINAL APPEALABLE ORDER. THIS CASE IS TERMINATED ON THE DOCKET. *****

IT IS SO ORDERED.


RICHARD A. FRYE, JUDGE

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CLERK

IN THE COMMON PLEAS COURT OF DARKE COUNTY, OHIO

IN THE MATTER OF:	:	CASE NO. 06-CV-63231
	:	
OHIO DEPARTMENT OF	:	
AGRICULTURE SUBPOENAS	:	
	:	JONATHAN P. HEIN, Judge

DECISION AND JUDGMENT ENTRY

This matter came before the Court pursuant to the motion to quash subpoenas filed on behalf of Dan Kremer and Paul Schmitzneyer on September 5, 2006. The movants were represented by David G. Cox, Esq. The Department of Agriculture was represented by James R. Patterson, Ass't Attorney General.

The matter was heard by the Court on September 6, 2006 by agreement of the parties. Arguments were presented by counsel with inquiry by the Court. Additionally, citations to case law and statutory authority were presented. The matter was taken under advisement by the Court for written decision.

Case Facts

The movants have received subpoenas issued by the Department of Agriculture pursuant to Chapter 119 of the Ohio Revised Code which direct the movants to appear at an administrative hearing being conducted by the Ohio Department of Agriculture. The subpoenas also direct the movants to bring with them various records regarding their dairy farm operation.

Paul and Carol Schmitmeyer raise approximately 100 dairy cows in Darke County. Mrs. Schmitmeyer holds a Grade A milk producers license issued by the Department of Agriculture. This license allows her to produce milk and sell it to a milk cooperative which collects the milk from numerous producers and then causes it to be pasturized before bottling and placing it into the public food supply. In 2004, the Schmitmeyers sold a 5% interest of their herd to various other owners who then have the right to their share of the milk produced from the herd. This ownership arrangement is described as a "herd share agreement." This milk is described as "raw milk" since it is not processed prior to consumption.

The Department of Agriculture claims that this transaction is a sale of raw milk which is prohibited by R.C. 917.04. The Department also claims that the delivery of this milk does not comply with the labeling requirements of the Revised Code and the Ohio Administrative Code. R.C. 917.04 provides as follows:

917.04 Sales of and labeling for raw milk.

No raw milk retailer shall sell, offer for sale, or expose for sale raw milk to the ultimate consumer except a raw milk retailer who, prior to October 31, 1965, was engaged continuously in the business of selling or offering for sale raw milk directly to ultimate consumers, holds a valid raw milk retailer license issued under section 917.09 of the Revised Code, and is subject to the rules regulating the sale of raw milk adopted under this chapter.

No person shall fail to label, in accordance with rules adopted by the director of agriculture under section 917.02 of the Revised Code, all final delivery containers used for the sale of raw milk to ultimate consumers with the words "this product has not been pasteurized and may contain disease-producing organisms."

The Schmitmeyers claim that "raw milk" provided under a herd share agreement is not regulated by Chapter 917 of the Revised Code since it is not within the definition of "milk" as described in R.C. 917.01(F) and not within the definition of a "dairy product" as described in R.C. 917.01(N). These sections are as follows:

(F) "Milk" means the lacteal secretion, substantially free from colostrum, obtained by the complete milking of one or more healthy cows, goats, sheep, or other animals and intended for either of the following purposes:

- (1) To be sold for human consumption or for use in dairy products;
- (2) To be used for human consumption or for use in dairy products on the premises of a governmental agency or institution.

"Milk" does not include a blend of the lacteal secretions of different species.

(N) "Dairy products" means milk, raw milk for sale to the ultimate consumer, grade A milk products, and manufactured milk products. [Emphasis added.]

Schmitmeyers' also claim that the milk is not being sold and that the owners are entitled to the milk due to their ownership interest in the dairy cows. The Department of Agriculture claims that the herd share agreement is a subterfuge to attempt to avoid compliance with the purpose of the law regulating the sale of raw milk, which public purposes are (1) to improve public health by preventing milk-borne pathogens and bacteria from being consumed by the public, and (2) to maintain public confidence in the quality of milk and dairy products – for the benefit of consumers and producers.

Legal Analysis

It is the Court's conclusion that the interpretation of various provisions of R.C. 917.01 is clouded because there is no definition of "sale" or "sold" in Chapter 9 of the Revised Code. [There are other references to "raw milk" in the Revised Code but always within the context of the sale of the milk to the consuming public; these other sections are not mentioned since they are not relevant to the issues before the Court.]

Schmitmeyers claim that they are not subject to the subpoena since the subject matter is a private contract involving private business records and the use to revoke their Grade A producer license is a violation of the Fourth and Fifth Amendments to the U.S. Constitution.

They cite *Boyd v. United States* (1886), 116 U.S. 616 and *Hale v. Hinkle* (1906), 201 U.S. 43.

While these decisions may more closely approximate the strict construction of the drafters of the U.S. Constitution and the full meaning of the enumeration clause of the 10th Amendment, the law has changed. The authority cited by the Department of Agriculture correctly states the current interpretation of the Fourth and Fifth Amendments that there is no violation of constitutional principles by use of subpoena powers for administrative proceedings. See *v. City of Seattle* (1967), 387 U.S. 541; *A.J.S. Szigetl v. Ohio Depart. of Commerce*, 1992 U.S. App. LEXIS 32101 (6th Cir. 1992). The subpoena must be honored by the recipient provided it is sufficiently limited in scope, relevant to the agency's purposes and not unduly burdensome.

In this case, the requested documents are relevant to the agency's inquiry. The records have not been described as voluminous or tedious to assemble. And since they have already been produced pursuant to a subpoena issued for a deposition, their production cannot now be described as burdensome.

Movants also challenge the use of the subpoenaed documents which previously requested for deposition purposes pursuant to R.C. 901.27. This section allows issuance of subpoenas by the Department of Agriculture for investigative purposes. Movants claim that disclosure of the information cannot be used in administrative proceedings under Chapter 119. However, the Court finds that the non-disclosure provisions of R.C. 901.27 do not apply to administrative proceedings under Chapter 119 since the non-disclosure is required except for "reports to the director [of the Department] or when called on to testify in any court proceedings..." This Court finds that non-disclosure applies to other entities, such as news agencies, private persons, competitors, etc.

The ultimate issue in this matter is whether the Department of Agriculture has authority to investigate the Movants for allegedly providing milk to owners under the herd share.

This analysis centers on the interpretation of "sale" and "sold." The knowledge of counsel for both parties and the passion of their argument should be commended. Under the time constraints involved, they have responded effectively to advocate on behalf of their clients.

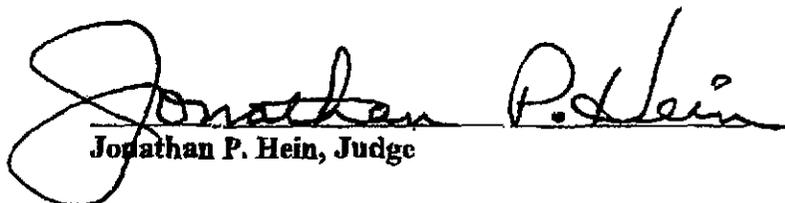
Admittedly, there are also many other unique and thought-provoking issues yet to be resolved. Does the Department have authority to regulate herd share agreements? What remedial opportunities must the Department offer prior to taking action on the Grade A producer license? Why are raw milk retail licenses authorized for issuance by the Director, but only for sellers operating before 1965 [see R.C. 917.09(A)(4) and 917.01(T)]? What is the extent of the government's role in regulating individual behavior, and its regulatory duty to consumers and other producers of milk and dairy products?

However, these issues are not currently before the Court. The issue regarding herd share agreements must first be determined by the administrative hearing officer at the Department of Agriculture. Thereafter, either party may appeal the decision to the Court of Common Pleas having jurisdiction – possibly including this Court. Therefore, these pressing issues are not ripe for adjudication.

Conclusion

From the arguments and legal authority presented, the Court finds that the Movants are required to produce the records and documents requested in the subpoena issued by the Ohio Department of Agriculture.

IT IS THEREFORE ORDERED AND DECREED that Dan Kremer and Paul Schmittmeyer are directed to comply with the administrative subpoenas issued by the Ohio Department of Agriculture for hearing on September 8, 2006. Their motion to quash is denied. Costs taxed to the parties equally. FINAL APPEALABLE ORDER.


Jonathan P. Hein, Judge

cc: David G. Cox, Attorney for Movants (via fax 614-228-0146)
James R. Patterson, Ass't Attorney General for Dept. of Agriculture (via fax 614-466-6124)

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LUCAS COUNTY

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COMMON PLEAS COURT
BERNIE GUILTER
CLERK OF COURTS

THIS IS A FINAL
APPEALABLE ORDER

IN THE COURT OF COMMON PLEAS OF LUCAS COUNTY, OHIO

Estate of Pauline J. Bundy,
By Oddlyn J. Stapelton, Executor,

Plaintiff,

vs.

Lucas County Department of Job
and Family Services, et al.,

Defendants.

* Case No. 05-2454
* OPINION AND JUDGMENT ENTRY
* Judge James D. Jensen
*
*
*
*

This matter is before the Court upon a motion for reconsideration filed by Defendant Ohio Department of Job and Family Services ("ODJFS") in which ODJFS asks this Court to reconsider an opinion and judgment entry filed July 13, 2005. In that opinion, this Court denied motions to dismiss filed by Defendant ODJFS and Defendant Lucas County Department of Job and Family Services ("Lucas County"). Upon consideration of the pleadings, memorandum of counsel, and applicable law, this Court finds Defendant's motion for reconsideration well-taken and is granted. Defendants' motions to dismiss are also well-taken and are granted.

I.

On October 9, 2003, Pauline J. Bundy filed an application with Lucas County seeking

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Medicaid and nursing home benefits. Ms. Bundy died on October 15, 2003. On December 11, 2003, Lucas County denied in part and granted in part Plaintiff's application. The Estate of Pauline J. Bundy appealed the Lucas County decision and was granted a state hearing under R.C. 5101.35(B). ODJFS affirmed the Lucas County decision on January 13, 2004. On April 4, 2005, plaintiff filed a declaratory judgment action with this court and subsequently amended its complaint. Defendant ODJFS filed a motion to dismiss the amended complaint on June 6, 2005. On June 9, 2005, plaintiff filed a memorandum in opposition to defendant's motion. Then, on June 17, 2005, defendant filed its reply to plaintiff's memorandum.

On July 13, 2005, this court entered an opinion and judgment entry denying ODJFS's motion pursuant to R.C. 5101.35(B) which provides, in relevant part:

A state hearing decision is binding upon the agency and department unless it is reversed or modified on appeal to the director of job and family services or a court of common pleas.

On August 1, 2005, ODJFS filed a motion for reconsideration. In its motion, Defendant asks this Court to reconsider its opinion and dismiss this action on the following grounds: (1) Plaintiff's declaratory judgment action is not an administrative appeal under R.C. 5101.35; (2) Plaintiff failed to exhaust administrative remedies; and (3) Plaintiff failed to file an administrative appeal within the deadlines established by OAC 5101:6-8-01(A)(4) and R.C. 5101.35.

On August 23, 2005, Plaintiff filed its memorandum in opposition to Defendant's motion for reconsideration. On September 1, 2005, Defendant filed its reply. On September 12, 2005, plaintiff filed a surrebuttal reply memorandum. On September 15, 2005, ODJFS filed a motion to strike plaintiff's surrebuttal. Then on September 20, 2005, ODJFS filed a memorandum in opposition to defendant's motion to strike. Oral arguments were heard November 10, 2005.

II.

A trial court may reconsider any decision rendered in a case if no final appealable order has been made. *Falcon Painting, Inc. v. Trustcorp, Bank, Ohio* (Nov. 8, 1991), Lucas App. No. L-90-285, unreported. The standards to be applied by the Court in reconsidering a ruling, are the same as those of the initial decision. *Id.* See also *Fidelity & Guaranty Ins. Underwriters, Inc. Vv. Aetna Casualty & Surety Co. Of Illinois* (June 30, 1993), Lucas App. No. L-92-024, unreported; *D'Agastino v. Uniroyal* (1998), 129 Ohio App. 3d 281, 717 N.E.2d 781 (holding a trial court “retains jurisdiction to reconsider an interlocutory order any time before entry of final judgment in the case, either sua sponte or upon motion,” citing *Pitts v. Ohio Dept. of Transp.* (1981), 67 Ohio St.2d 378, 379-380, 423 N.E.2d 1105).

In the instant case, the opinion and judgment entry filed July 13, 2005, did not state that the judgment was final and appealable. Consequently, this Court retains jurisdiction and may reconsider its opinion.

III.

In its motion for reconsideration, ODJFS argues that if this action is an appeal of the state hearing decision, it was not filed within the statutory guidelines. This court agrees. R.C. 119.12 provides, in relevant part:

Any party desiring to appeal shall file a notice of appeal with the agency setting forth the order appealed from and the grounds of the party's appeal. A copy of such notice of appeal shall also be filed by the appellant with the court. Unless otherwise provided by law relating to a particular agency, such notices of appeal *shall be filed within fifteen days* after the mailing of the notice of the agency's order * * *.

(emphasis added). Here, Plaintiff did not file a notice of appeal with ODJFS within fifteen days of the state hearing decision. Therefore, this action was not timely filed as an appeal.

However, the parties assert that this action is not an appeal from an administrative decision, but an "original action." Therefore, this Court must determine if the amended complaint, as an original action, states a claim upon which relief can be granted. Plaintiff's complaint is based upon its claim that Defendants have intentionally and purposefully denied Plaintiff equal protection under the law, as prescribed by the U.S. Constitution, and that pursuant to Civ.R. 57, Plaintiff is entitled to a declaration of this Court concerning the rights and obligations of the parties to receive and provide nursing home vendor payments. In oral argument, Plaintiff asserted that its claim is not a facial attack on the validity of OAC 5101:1-39-32 and OAC 5101:1-39-072; but that a controversy exists as to whether these provisions were applied appropriately.

Section 1983, Title 42, U.S. Code ("Section 1983"), provides a remedy to persons whose federal rights have been violated by governmental officials. *Mankins v. Paxton* (2001), 142 Ohio App.3d 1, 9, 753 N.E.2d 918, citing *Shirokey v. Marth* (1992), 63 Ohio St.3d 113,116, 585 N.E.2d 407-409-410. The elements of a Section 1983 claim are that the conduct in controversy must be committed by a *person* acting under color of state law, and the conduct must deprive the plaintiff of rights, privileges, or immunities secured by the constitution or laws of the United States. *Mankins*, 142 Ohio App.3d at 10. However, neither LCDJFS nor ODJFS is a "person" subject to suit under Section 1983. *Morning View Care Center-Fulton v. Ohio Dept. of Human Services*, 148 Ohio App.3d 518, 774 N.E.2d 300, 2002-Ohio-2878, ¶ 29. See also *Shaper v. Tracy* (1994), 97 Ohio App.3d 760, 766, 647 N.E.2d 550, 553-554. Therefore, Plaintiff's equal protection claim fails to state a claim for the purposes of Section 1983.

Nevertheless, even if this Court had found that plaintiff's constitutional argument was properly pled, "constitutional questions will not be decided until the necessity for their decision

arises.” *State ex rel. Lieux v. Village of Westlake* (1951), 154 Ohio St. 412, 415, 96 N.E.2d 414. In *Avery v. Rossford, Ohio Transp. Improvement Dist.* (2001), 145 Ohio App.3d 155, 762 N.E.2d 388, the Sixth District Court of Appeals opined that the exhaustion of administrative remedies is “usually required in order to prevent a premature interference with agency processes. This permits the agency to function efficiently and provides it with ‘an opportunity to correct its own errors, to afford the parties and the courts the benefit of its experience and expertise, and to compile a record which is adequate for judicial review.’ Id. at 163, citing *Nemazee v. Mt. Sinai Med. Ctr.* (1990), 56 Ohio St.3d 109, 111, 564 N.E.2d 477, quoting *Weinberger v. Salfi* (1975), 422 U.S. 749, 465, 95 S.Ct. 2457.

While recognizing that administrative agencies generally cannot address the question of whether a statute or rule is unconstitutional,¹ the *Avery* Court found that due process claims such as “lack of notice, lack of opportunity to be heard, and excessive assessments * * * are all issues that could be addressed in the administrative process.” *Avery*, 145 Ohio App.3d at 163. The *Avery* Court reasoned:

[C]ompared to seeking a declaration on the constitutionality of a statute, it is an entirely different matter to assert that a party’s actions were unconstitutional. That kind of allegation does not draw into question the validity of the statute or law. Instead, it questions whether the party’s actions were in accordance with the law. Administrative review is suited to that task, and this is a quasi-judicial function that could be performed by the board of review.

(Citations omitted). Id at 163-164.

Similarly, in *State ex rel. Lieux v. Westlake* (1951) 154 Ohio St. 412, 415, the Supreme Court found that the question of whether a zoning ordinance was constitutional, as applied, was

¹ The Supreme Court of Ohio has held that “an administrative agency is without jurisdiction to determine the constitutional *validity* of a statute.” *Herrick v. Kosydar* (1975), 44 Ohio St.2d 128, 130, 339 N.E.2d 626 (emphasis added).

not ripe for consideration because the challenger did not seek relief from an available administrative remedy. The *Lieux* Court reasoned that had the challenger sought relief from the administrative remedy, “then [she] would not be prejudiced by the zoning ordinance which she seeks to have declared unconstitutional.” *Id.*

In the case at bar, Plaintiff seeks a declaration of this Court that Defendants misapplied certain provisions of the Ohio Administrative Code when it denied benefits to Plaintiff. Under *Avery* and *Lieux*, Plaintiff was required to exhaust its administrative remedies before raising its constitutional claims in the present proceeding because Plaintiff’s claims do not question the validity of the OAC provisions – only their application.²

Assuming *arguendo* Plaintiff was not required to exhaust her administrative remedies in the present proceeding, Defendants argue that Plaintiff’s complaint should be dismissed because the unappealed state hearing decision was final and conclusive, therefore, *res judicata*. “The doctrine of *res judicata* involves both claim preclusion (historically called estoppel by judgment in Ohio) and issue preclusion (traditionally known as collateral estoppel).” *Chagrin Falls v. Geauga Cty. Bd. of Commrs.*, 11th Dist. No. 2003-G-2530, 2004-Ohio-5310, at ¶28 (citations omitted). The Supreme Court of Ohio has held that “*res judicata*, whether issue preclusion or claim preclusion, applies to those administrative proceedings which are ‘of a judicial nature and

² Plaintiff relies on the Supreme Court’s decision in *Jones v. Village of Chagrin Falls*, 77 Ohio St.3d 456, 460-461, 674 N.E.2d 1388, 1997-Ohio-253, for the proposition that it is not required to exhaust administrative remedies before filing a declaratory judgment action to determine constitutional claims. However, while finding that “administrative bodies have no authority to interpret the Constitution” and “requiring litigants to assert constitutional arguments administratively would be a waste of time and effort for all involved,” *Id.* at 460-461, the *Jones* Court stipulated “our holding is not to be read as a rejection of the force of the doctrine requiring exhaustion of administrative remedies in general.” *Id.* at 462. Rather, “it is the long settled rule of judicial administration that no one is entitled to judicial relief for a supposed or threatened injury until the prescribed administrative remedy is exhausted.” *Id.*

where the parties have had an ample opportunity to litigate the issues involved in the proceeding * * *.” *Set Products, Inc. v. Bainbridge Twp. Bd. of Zoning Appeals* (1987), 31 Ohio St.3d 260, 263, 510 N.E.2d 373, quoting *Superior's Brand v. Lindley* (1980), 62 Ohio St.2d 133, 403 N.E.2d 996, syllabus. R.C. 5101.35 provides, in pertinent part:

(B) * * * an appellant who appeals * * * a decision or order of an agency administering a family services program shall, at the appellant's request, be granted a state hearing by the department of job and family services. * * * A state hearing decision is binding upon the agency and department, unless it is reversed or modified on appeal to the director of job and family services or a court of common pleas.

(C) * * * an appellant who disagrees with a state hearing decision may make an administrative appeal to the director of job and family services * * *. This administrative appeal does not require a hearing, but the director or the director's designee shall review the state hearing decision and previous administrative action and may affirm, modify, remand, or reverse the state hearing decision. * * * An administrative appeal decision is the final decision of the department and is binding upon the department and agency, unless it is reversed or modified on appeal to the court of common pleas.

* * *

(E) An appellant who disagrees with an administrative appeal decision of the director of job and family services or the director's designee issued under division (C) of this section may appeal from the decision to the court of common pleas pursuant to section 119.12 of the Revised Code. * * *.

Because the procedures specified in R.C. 5101.35, enable an applicant to appeal to a court of common pleas, the hearings are judicial in nature.

For the foregoing reasons, defendants' motion to dismiss plaintiff's first amended complaint is well-taken and is granted.

THIS IS A FINAL
APPEALABLE ORDER

JUDGMENT ENTRY

It is ORDERED that the motion for reconsideration filed by the Ohio Department of Job and Family Services is GRANTED.

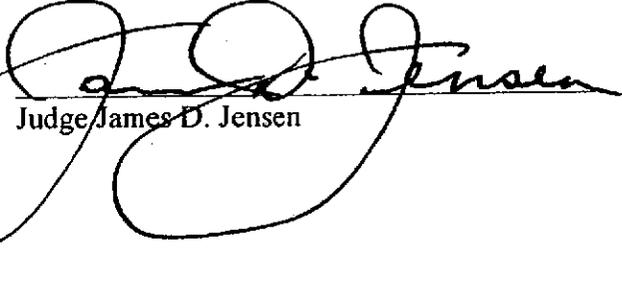
It is ORDERED that Defendants' motion to dismiss is GRANTED.

It is further ORDERED the Plaintiff's complaint against Defendant Ohio Department of Job and Family Services and Defendant Lucas County Department of Job and Family Services is hereby dismissed pursuant to Civ.R. 41(B)(4).

It is further ORDERED that the Clerk of Courts shall serve a copy of this Judgment Entry upon all parties.

THIS IS A FINAL APPEALABLE ORDER.

November 22, 2005


Judge James D. Jensen

cc: David J. Espinoza, Esq.
Willard A. Johnson, Esq.
Peter N. Kanios, Esq.

1 of 3 DOCUMENTS



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As of: Dec 12, 2006

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*** ARCHIVE DATA ***

*** THIS DOCUMENT IS CURRENT THROUGH JANUARY 1, 2005 ***

5101:3 DIVISION OF MEDICAL ASSISTANCE
Chapter 5101:3-42 Medicaid Home and Community-Based Services Level One Waiver Program

OAC Ann. 5101:3-42-01 (Anderson 2005)

5101:3-42-01 Medicaid home and community-based services program - level one waiver.

(A) The purpose of this rule is to establish the level one waiver as a component of the medicaid home and community-based services program pursuant to *sections 5111.87 and 5111.85 of the Revised Code*.

(1) The level one waiver program provides necessary waiver services to individuals of any age who meet the level of care criteria for an intermediate care facility for individuals with mental retardation and other developmental disabilities (ICF/MR) as set forth in rule 5101:3-3-07 of the Administrative Code, and other eligibility requirements established in this rule.

(2) The Ohio department of mental retardation and developmental disabilities (ODMRDD), through an interagency agreement with the Ohio department of job and family services (ODJFS), administers the level one waiver on a daily basis in accordance with *section 5111.86 of the Revised Code*.

(B) Definitions

(1) "Home and community-based services" (HCBS) means any federally approved medicaid waiver service provided to a waiver enrollee as an alternative to institutional care under Section 1915c of the Social Security Act.

(2) "Local medicaid administrative authority" (LMAA) means the statutory authority of each county board of mental retardation and developmental disabilities (CBMRDD) to administer a component of the medicaid home and community-based services program as specified in *section 5126.055 of the Revised Code*.

(3) "Provider" means a person or agency certified by ODMRDD that has met the provider qualification requirements to provide specific waiver services, as specified in paragraph (J)(1) of this rule, with a valid medicaid provider agreement as specified in paragraph (J)(3) of this rule.

(4) "Prior authorization" means the process of authorizing institutional respite, informal respite, transportation, homemaker/personal care, and environmental accessibility adaptations during the initial ISP meeting or as part of the process to make a change in the ISP when a change in need has been identified. The requested services shall be prior authorized when the benefit has or will exceed the service specific benefit limitation but is within the total combined benefit limitation specified in paragraph (G) of this rule and when no assessment that contraindicates the need for the service exists.

(C) Application for the level one waiver

(1) Individuals seeking to enroll in the level one waiver program must complete the JFS Form 02399 "The Application for Home and Community-based Services." Applications shall be available at all local county boards of mental

retardation and developmental disabilities (CBMRDD), which act as the LMAA for the level one waiver program. Applications are also available at the local county department of job and family services (CDJFS).

(2) The LMAA is responsible for explaining to individuals requesting HCBS the services available through the level one waiver benefit package including the amount, scope and duration of services and the benefit package limitations.

(D) Eligibility criteria for the level one waiver

(1) Individuals applying for the level one waiver program must require the level of care provided in an ICF/MR and be eligible for ICF/MR services upon initial enrollment and no later than every twelve months thereafter, as specified in rules 5101:3-3-07 and 5123:2-8-12 of the Administrative Code. An individual must be determined eligible for an ICF/MR level of care upon the effective date of enrollment in the level one waiver program; and

(2) Individuals applying for the level one waiver program must meet financial eligibility criteria as specified in Chapter 5101:1-39 of the Administrative Code and

(3) The individual's health and welfare needs must be assured through the utilization of level one waiver services in addition to other formal and informal supports regardless of funding source.

(E) Level one waiver enrollment, continued enrollment, and disenrollment

(1) Individuals, who meet the eligibility criteria established in paragraph (D) of this rule, or their legal representative shall be informed of the following:

(a) Any feasible alternative under the waiver; and

(b) Given the choice of either institutional or home and community-based services.

(2) Individuals determined eligible for the level one waiver program in accordance with paragraph (D) of this rule who are seeking to enroll in the level one waiver program must participate in a prescreening assessment process. This process evaluates whether health and welfare needs can be met with the level of service provided through the level one waiver program, combined with other non-waiver services regardless of funding source when applicable, and within the benefit package limitations specified in paragraph (G) of this rule. The prescreening assessment process shall be conducted in accordance with rule 5123:2-9-01 of the Administrative Code.

(a) If the prescreening assessment process indicates that the eligible individual's health and welfare needs cannot be met with the level of services provided through the level one waiver program, combined with other non-waiver services regardless of funding sources when applicable, and within the benefit package limitations specified in paragraph (G) of this rule, then the individual shall not be enrolled in the level one waiver program and notification of hearing rights shall be provided as established in paragraph (O) of this rule and in accordance with rule 5123:2-9-01 of the Administrative Code; or

(b) If the prescreening assessment process indicates that the eligible individual's health and welfare needs can be met with the level of services provided through the level one waiver program, and combined with other non-waiver services regardless of funding source when applicable, and within the benefit package limitations specified in paragraph (G) of this rule, then the individual will continue with enrollment in the level one waiver program in accordance with this rule and with rule 5123:2-9-01 of the Administrative Code.

(3) ODMRDD shall allocate waiver slots to the LMAA in accordance with rule 5123:2-9-03 of the Administrative Code.

(4) The LMAA shall offer available level one waiver slots to eligible individuals in accordance with applicable waiting list category requirements as set forth in rules 5101:3-41-05 and 5123:2-1-08 of the Administrative Code.

(5) The statewide maximum number of individuals that can be enrolled in the level one waiver program at any given time cannot exceed three thousand for the first waiver year, five thousand for the second waiver year, and six thousand for the third waiver year.

(6) An individual's continued enrollment in the level one waiver program shall be re-determined in twelve month increments beginning with the individual's initial enrollment date. An individual must continue to meet the eligibility criteria established in paragraph (D) of this rule and the individual's health and welfare needs must continue to be met in accordance with paragraph (E)(2)(b) of this rule.

(7) Disenrollment of level one waiver participants shall be done in accordance with the provisions set forth in this rule and with rule 5123:2-9-01 of the Administrative Code.

(a) Individuals enrolled in the level one waiver program shall not be disenrolled from the waiver due to an increase in the need for a covered service(s) that causes the total need for the covered service(s) to exceed the benefit package limitations, as specified in paragraph (G) of this rule, unless the LMAA has evaluated the individual and determined that the individual's health and welfare cannot be assured by doing the following:

- (i) Adding a higher level of available natural supports; and/or
- (ii) Prior authorizing additional services covered through the level one waiver benefit package; and/or
- (iii) Accessing emergency services covered through the level one waiver benefit package; and/or
- (iv) Accessing additional non-waiver services other than natural supports; and/or
- (v) Accessing funds placed in a local or state risk fund in accordance with rule 5123:1-5-02 of the Administrative Code

(b) If the activities identified in paragraph (E)(7)(a) of this rule are unsuccessful and it is determined that services are not sufficient to assure the individual's health and welfare then the following will apply:

(i) The individual will be given the opportunity to apply for an alternate home and community-based waiver program, to the extent that such waiver openings exist, that may be more adequate in meeting the individual's service needs. An individual may take priority over others waiting for waiver services if they meet one of the waiting list priority categories which includes emergency situations as established in rule 5123:2-1-08 of the Administrative Code;

(ii) The individual will be offered an opportunity for placement in an ICF/MR to include a state operated development center;

(c) Individuals enrolled in the level one waiver program who are recommended for disenrollment from the waiver program shall be given notification of hearing rights as established in paragraph (O) of this rule.

(F) The level one waiver program benefit package consists of the following services:

- (1) Homemaker / personal care;
- (2) Institutional respite;
- (3) Informal respite;
- (4) Transportation;
- (5) Environmental accessibility adaptations;
- (6) Personal emergency response systems (PERS);
- (7) Specialized medical adaptive / assistive equipment and supplies;
- (8) Emergency assistance;

(G) Benefit package limitations for level one waiver services

(1) Individuals enrolled in the level one waiver program are subject to the benefit package limitations for specific level one waiver services. ODMRDD, as the level one waiver program administrator, shall have mechanisms in place to ensure that applicants or individuals enrolled in the level one waiver program do not exceed the benefit limitations as identified in paragraphs (G)(2) to (G)(4) of this rule.

(2) The following services are subject to specific benefit limitations that when combined cannot exceed the maximum of five thousand dollars effective in twelve month increments beginning with the individual's enrollment date:

(a) Homemaker/personal care services are subject to a benefit limitation in the amount of one thousand dollars which will be approved at a higher amount through the prior authorization process if an assessed need for the additional service exists and if the total expenditures for this service do not exceed the five thousand dollar maximum specified in paragraph (G)(2) of this rule;

(b) Institutional respite services are subject to a benefit limitation in the amount of one thousand dollars which will be approved at a higher amount through the prior authorization process if an assessed need for the additional services exists and if the total expenditures for the service do not exceed the five thousand dollar maximum specified in paragraph (G)(2) of this rule;

(c) Informal respite services are subject to a benefit limitation in the amount of two thousand five hundred dollars which will be approved at a higher amount through the prior authorization process if an assessed need for the additional services exists and if the total expenditures for the service do not exceed the five thousand dollar maximum specified in paragraph (G)(2) of this rule;

(d) Transportation services are subject to a benefit limitation in the amount of five hundred dollars which will be approved at a higher amount through the prior authorization process if an assessed need for the additional services exists and if the total expenditures for the service do not exceed the five thousand dollar maximum specified in paragraph (G)(2) of this rule.

(3) The following benefits are subject to specific benefit limitations that when combined cannot exceed the maximum of six thousand dollars effective during the initial three year period of the level one waiver program.

(a) Environmental accessibility adaptations are subject to a benefit limitation in the amount of two thousand dollars which can be approved at a higher amount through the prior authorization process not to exceed the six thousand dollar maximum specified in paragraph (G)(3) of this rule effective during the initial three year period of the level one waiver program. The individual's usage of this benefit shall be evaluated at least every twelve months through the ISP process in order to consider the remaining value of the benefit and future usage as the individual's needs indicate. The individual's enrollment date within the initial three-year period shall not affect the benefit amount;

(b) Personal emergency response systems (PERS) are subject to a benefit limitation not to exceed two thousand dollars effective during the initial three year period of the level one waiver program. The individual's usage of this benefit shall be evaluated at least every twelve months through the ISP process in order to consider the remaining value of the benefit and future usage as the individual's needs indicate. The individual's enrollment date within the initial three year period shall not affect the benefit amount;

(c) Specialized medical equipment and supplies are subject to a benefit limitation not to exceed two thousand dollars effective during the initial three year period of the level one waiver program. The individual's usage of this benefit shall be evaluated at least every twelve months through the ISP process in order to consider the remaining value of the benefit and future usage as the individual's needs indicate. The individual's enrollment date within the initial three year period shall not affect the benefit amount.

(4) Emergency assistance services are subject to a benefit limitation not to exceed eight thousand dollars during the initial three-year period of the level one waiver program. The individual's usage of this benefit shall be evaluated at least every twelve months through the ISP process in order to consider the remaining value of the benefit and future usage as the individual's needs indicate. Emergency assistance services do not include informal respite. The individual's enrollment date within the initial three-year period shall not affect the benefit amount.

(H) Level one waiver individual service plan requirements

(1) All services shall be provided to individual enrolled on the level one waiver pursuant to a written individual service plan (ISP).

(2) Licensed facilities shall develop the ISP for each individual in accordance with rule 5123:2-3-17 of the Administrative Code.

(3) The ISP shall be developed by qualified persons with input from the individual level one waiver enrollee and the service and support administrator (SSA), who is designated by the LMAA in accordance with *section 5126.15 of the Revised Code*. Providers of homemaker / personal care services shall participate in the ISP meetings when a request for their participation is made by the individual enrollee.

(a) The ISP shall list the level one waiver services and the non-waiver services, regardless of funding source, that are necessary to ensure the enrollee's health and welfare.

(b) The ISP shall contain the following medicaid required elements:

(i) Type of service to be provided; and

(ii) Amount of service to be provided; and

(iii) Frequency and duration of each service; and

(iv) Type of provider to furnish each service.

(c) The ISP is subject to approval by ODJFS and ODMRDD pursuant to *section 5111.871 of the Revised Code*.

(I) Freedom of choice of provider

Individuals enrolled in the level one waiver program shall be given a free choice of qualified level one waiver providers. A provider is qualified if they meet the standards established in paragraph (J) of this rule. ODMRDD shall communicate to the LMAA and to the individuals and to individuals enrolled in the level one waiver program those providers who are qualified to provide level one waiver services in accordance with *section 5126.046 of the Revised Code*.

(J) Provision of level one waiver services

(1) Level one waiver services shall be provided by individuals or agencies who hold certification for each service they provide in accordance with rules 5123:2-8-03, 5123:2-8-04, 5123:2-8-06, 5123:2-8-07, 5123:2-8-08, 5123:2-8-09, 5123:2-8-10, and 5123:2-8-11 of the Administrative Code; and

(a) A provider licensed pursuant to *section 5123.19 of the Revised Code* is subject to rule 5123:2-3-19 of the Administrative Code.

(b) A provider certified to provide supported living service pursuant to *section 5126.431 of the Revised Code* is subject to rule 5123:2-12-06 of the Administrative Code.

(2) Each provider applicant shall adhere to the process set forth in rule 5123:2-8-02 of the Administrative Code in order to obtain the applicable certification specified in paragraph (J)(1) of this rule; and

(3) Level one waiver services shall be provided only by individuals or agencies who have a valid medicaid provider agreement in accordance with rule 5101:3-1-17.2 of the Administrative Code; and

(4) Level one waiver services shall be provided only to individuals who have met the eligibility requirements in paragraph (D) of this rule and have been enrolled in the level one waiver program at the time of service delivery; and

(5) Level one waiver services shall be provided in accordance with each enrollee's individual service plan as specified in paragraph (H) of this rule; and

(6) Each certified level one waiver provider shall have a valid contract as specified in paragraph (K) of this rule prior to the provision of level one waiver services.

(K) Provider contracts

The LMAA shall contract with a certified level one waiver provider that the individual waiver enrollee chooses if the provider is qualified and agrees to provide the services. The contract shall comply with any applicable standards established by ODJFS.

(L) Provider payment standards

Payments for the provision of level one waiver services shall be made to certified level one waiver providers in accordance with rules 5101:3-42-11 and 5123:2-8-16 of the Administrative Code.

(M) Provider complaint and dispute resolution

In addition to any other remedies available to a medicaid provider, CBMRDD, as the LMAA, as well as individual and agency providers of level one waiver services are subject to the provisions set forth in *section 5126.036 of the Revised Code* regarding the resolution of complaints and disputes.

(N) Monitoring, compliance and sanctions

ODJFS shall conduct periodic monitoring and compliance reviews related to the level one waiver program in accordance with *section 5111.85 of the Revised Code*. Reviews may consist of, but are not limited to, physical inspections of records and sites where services are provided, interviews of providers, recipients, and administrators of waiver services. Certified level one waiver providers, in accordance with the medicaid provider agreement, ODMRDD, and CBMRDD shall furnish to ODJFS, the center for medicare and medicaid services (CMS), and the medicaid fraud con-

trol unit or their designees any records related to the administration and/or provision of level one waiver services. Individuals enrolled in the level one waiver program shall cooperate with all monitoring, compliance and quality assurance reviews conducted by ODJFS, CMS and the medicaid fraud control unit or their designee.

(O) Due process

(1) Applicants for level one waiver enrollment and waiver enrollees who are affected by any decision made by ODMRDD and/or ODJFS as recommended by the LMAA, to approve, reduce, deny or terminate enrollment or to change the level and/or type of waiver service delivered shall be afforded medicaid due process in accordance with *section 5101.35 of the Revised Code* through the state fair hearing process, and as specified in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code.

(2) If an applicant or enrollee requests a hearing, as specified in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code, the participation of ODMRDD, and/or ODJFS, and the LMAA is required during the hearing proceedings to justify the decision under appeal, in accordance with *section 5126.055 of the Revised Code*.

(3) All rules related to medicaid due process shall be interpreted in a manner consistent with *section 1.11 of the Revised Code*, which requires that they be liberally construed in order to promote their objective and assist the individual in obtaining justice. All rules relating to the right to a hearing and limitations on that right shall be interpreted in favor of the right to a hearing.

(P) Designation of local matching funds

County boards of mental retardation and developmental disabilities that have local medicaid administrative authority shall be responsible for payment of the state matching funds for each individual enrolled in the level one waiver program in accordance with *5126.057 of the Revised Code* and shall be subject to the procedures set forth in rule 5123:2-9-02 of the Administrative Code.

Eff 4-28-03

Rule promulgated under: *RC 119.03*

Rule authorized by: *RC 5111.85*

Rule amplifies: *RC 5111.85, 5111.86, 5111.87, 5111.871, 5111.042, 5123.0410, 5123.045, 5126.046, 5126.055, 5126.15*

R.C. 119.032 review dates: 04/28/2008