STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT 06105-3725

[REDACTED], 2014
Signature Confirmation

Client ID # [REDACTED]
Request # 605871

NOTICE OF DECISION

PARTY

[REDACTED]
C/o Atty. [REDACTED]
[REDACTED]
[REDACTED]

PROCEDURAL BACKGROUND

On [REDACTED] 2014, the Department of Social Services (the "Department") sent [REDACTED] (the Appellant") a Notice of Action ("NOA") informing her that she was required to contribute $2,145.91 toward the cost of her care each month under the Long Term Care Medical Assistance ("LTC") program effective [REDACTED] 2013.

On [REDACTED], 2014, the Appellant's legal counsel requested an administrative hearing to contest the Department's calculation of the applied income amount.

On [REDACTED], 2014, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") scheduled an administrative hearing for [REDACTED], 2014.

On [REDACTED], 2014, in accordance with sections 17b-60, 17b-61, and 4-176e to 4-189, inclusive, of the Connecticut General Statutes, OLCRAH held an administrative hearing.

The following individuals were present at the hearing:

[REDACTED] Power of Attorney for the Appellant
[REDACTED], Power of Attorney for the Appellant
Attorney [REDACTED], Appellant's Legal Representative
Jaimie LaChapelle, Department's Representative
Christopher Turner, Hearing Officer

STATEMENT OF THE ISSUE

The issue is whether the Department has correctly calculated the amount of applied income that the Appellant is responsible to pay the facility for the cost of her long-term care.

FINDINGS OF FACT

1. On [redacted] 2013, the Department received an application for Title 19 to cover the Appellant's stay in a long-term care facility. (Hearing summary)

2. The Appellant receives $1,507.00 per month in gross Social Security benefits. (Hearing summary, Testimony)

3. The Appellant receives $656.22 per month in gross pension benefits. (Hearing summary, Testimony)

4. On [redacted] 2013, the Appellant's State of Connecticut pension check increased to $675.91. (Exhibit P: Bank statement's)

5. The Appellant does not have a spouse residing in the community. (Testimony)

6. The Appellant does not have private medical insurance coverage in which she incurs a monthly insurance premium. (Testimony)

7. The Appellant does not pay a monthly premium for her Medicare Part B coverage. (Record)

8. The Appellant has a total monthly allowable deduction of $60.00 as her personal needs allowance ("PNA"). (Hearing summary)

9. On [redacted] 2014, the Appellant's Social Security benefit increased to $1,530.00. (Exhibit S: Department's narrative)

10. On [redacted] 2014, the Department issued a NOA indicating the Appellant must pay $2,145.91 for the cost of her care effective [redacted] 2014. (Exhibit U: NOA dated [redacted]/14)

11. On [redacted], 2014, the Department's representative entered a $70,152 medical diversion, at the request of [redacted] Health Care, for the period of [redacted] 2013 through [redacted] 2013. (Hearing summary; Record)

CONCLUSIONS OF LAW

1. Section 17b-2 of the Connecticut General Statutes ("CGS") authorizes the Commissioner of the Department of Social Services to administer the Medicaid program.

2. Uniform Policy Manual ("UPM"), Section 5000.01 provides definitions as follows:

   Available income is all income from which the assistance unit is considered to benefit, either through actual receipt or by having the income deemed to exist for its benefit.

   Applied income is that portion of the assistance unit's countable income that remains after all deductions and disregards are subtracted.

   Counted income is that income which remains after excluded income is subtracted from the total of available income.

   Deductions are those amounts which are subtracted as adjustments to counted income and which represent expenses paid by the assistance unit.

   Disregards are those amounts which are subtracted as standard adjustments to countable income and which do not represent expenses paid by the assistance unit.

3. UPM § 5005 (C) provides that the Department computes applied income by subtracting certain disregards and deductions, as described in this section, from counted income.

4. UPM § 5005 (D) provides that the Department uses the assistance unit's applied income to determine income eligibility and to calculate the amount of benefits.

5. The Department correctly determined the Appellant's total monthly gross unearned income is $2,163.22 ($1,507.00 + $656.22) for the period of ████ 2012 through ████ 2013.

6. The Department correctly determined the Appellant's total monthly gross unearned income is $2,182.91 ($1,507.00 + $675.91) for the period of ████ 2013 through ████████ 2013.

7. The Department correctly determined the Appellant's total monthly gross unearned income is $2,205.91 ($1,530.00 + $675.91) for the period of ██████ 2014 through ████ 2014.

8. As a resident of a LTCF, the Appellant is responsible for contributing a portion of her income towards the cost of her care.

9. UPM § 5035.20 provides that for residents of long term care facilities (LTCF) and those individuals receiving community-based services (CBS) when the individual does not have a spouse living in the community, total gross income is adjusted by certain deductions to calculate the amount of income which is to be applied to the monthly cost of care.

10. UPM § 5035.20 (B) provides that the following monthly deductions are allowed from the income of assistance units in LTCF's:

    (1) for veterans whose VA pension has been reduced to $90.00 pursuant to P.L. 101-508, for spouses of deceased veterans whose pension has been similarly reduced pursuant to P.L. 101-508, as amended by Section 601 (d) of P.L. 102-568, a personal needs allowance equal to the amount of their VA pension and the personal needs allowance described in 2. below;

    (2) a personal needs allowance of $50.00 for all other assistance units, which, effective July 1, 1999 and annually thereafter, shall be increased to reflect the annual cost of living adjustment used by the Social Security Administration;

    (3) an amount of income diverted to meet the needs of a family member who is in a community home to the extent of increasing his or her income to the MNIL which corresponds to the size of the family;

    (4) Medicare and other health insurance premiums, deductibles, and coinsurance costs when not paid for by Medicaid or any other third party;

    (5) costs for medical treatment approved by a physician which are incurred subsequent to the effective date of eligibility and which are not covered by Medicaid;

    (6) expenses for services provided by a licensed medical provider in the six month period immediately preceding the first month of eligibility providing the following conditions are met:

        a. the expenses were not for LTCF services, services provided by a medical institution equivalent to those provided in a long term care facility, or home and community-based services, when any of these services were incurred during a penalty period resulting from an improper transfer of assets; and

        b. the recipient is currently liable for the expenses; and

        c. the services are not covered by Medicaid in a prior period of eligibility.

11. Public Act 11-44 provides the procedures to decrease the personal needs allowance ("PNA") of Medicaid recipients who reside in a long-term care facility from $69.00 to $60.00 per month. Public 11-44 required the Department to reduce the PNA for residents of long-term care facilities, effective July 1, 2011.

12. UPM § 5045.20 provides that assistance units who are residents of Long Term Care Facilities or receiving Community Based Services are responsible for contributing a portion of their income toward the cost of their care. For LTCF cases only, the amount to be contributed is projected for a six-month period.

13. UPM § 5045.20 (A) provides that the amount of income to be contributed is calculated using the post-eligibility method starting with the month in which the 30th day of continuous LTCF care or receipt of community-based services occurs, and ending with the month in which the assistance unit member is discharged from the LTCF or community-based services are last received.

14. The Department correctly determined the Appellant entered ████ Health Care in ████ 2013 and the 30th day of continuous care takes place in ████ 2013.

15. UPM § 5045.20 (B) (1) (b) provides that total gross income is reduced by post-eligibility deductions (Cross reference: 5035-"Income Deductions") to arrive at the amount of income to be contributed.

16. UPM § 5045.20 (D) provides that the difference between the assistance unit's contribution and the Medicaid rate of the LTCF or CBS is the amount of benefits paid by the Department to the facility or provider organization on the unit's behalf.

17. The Department correctly allowed for the deduction of the $60.00 PNA from the Appellant's gross income.

18. The Department correctly determined that effective ████ 2014 the amount of income the Appellant is required to contribute to the cost of her medical care is $2,145.91 ($2,205.91 Gross Income - $60.00 PNA).

DISCUSSION

The regulation requires that residents of LTCF are responsible for contributing a portion of their income toward the cost of their medical care. In the Appellant's situation, the record established that she is a resident of a LTCF, and therefore, she must contribute a portion of her income towards the cost of her medical care.

The Appellant's representative argued that the Department should allow a diversion to pay for the Appellant's outstanding medical bill owed the nursing home. The Department provided the Appellant a diversion of her income to cover the period of ███ 2013 through ███████ 2013. The Appellant is eligible for LTC Medicaid for the period of ████ 2013, ███ 2013, ███ 2013, and ████ 2013. The Appellant's assets exceed the Medicaid asset limit for ██████ 2013 and the period of ███ 2013 through ███████ 2013.

The Department calculated the amount of the Appellant's monthly-applied income after allowing for all permissible deductions. The Department's calculation of the amount of income to be applied towards the Appellant's monthly cost of care is correct and in accordance with the regulation.

DECISION

The Appellant's appeal is **DENIED**.

Christopher Turner
Hearing Officer

Cc: Musa Mohamud, Hartford Operations Manager
Elizabeth Thomas, Hartford Operations Manager
Atty. ████████████████████████████████

RIGHT TO REQUEST RECONSIDERATION

The Appellant has the right to file a written reconsideration request within **15** days of the mailing date of the decision on the grounds there was an error of fact or law, new evidence has been discovered or other good cause exists. If the request for reconsideration is granted, the appellant will be notified within 25 days of the request date. No response within **25** days means that the request for reconsideration has been denied. The right to request a reconsideration is based on §4-181a (a) of the Connecticut General Statutes.

Reconsideration requests should include specific grounds for the request: for example, indicate what error of fact or law, what new evidence, or what other good cause exists.

Reconsideration requests should be sent to: Department of Social Services, Director, Office of Legal Counsel, Regulations and Administrative Hearings, 55 Farmington Avenue, Hartford, CT 06105.

RIGHT TO APPEAL

The Appellant has the right to appeal this decision to Superior Court within **45** days of the mailing of this decision, or 45 days after the agency denies a petition for reconsideration of this decision. The right to appeal is based on §4-183 of the Connecticut General Statutes. To appeal, a petition must be filed at Superior Court. A copy of the petition must be served upon the Office of the Attorney General, 55 Elm Street, Hartford, CT 06106, or the Commissioner of the Department of Social Services, 55 Farmington Avenue, Hartford, CT 06105. A copy of the petition must also be served on all parties to the hearing.

The 45-day appeal period may be extended in certain instances if there is good cause. The extension request must be filed with the Commissioner of the Department of Social Services in writing no later than 90 days from the mailing of the decision. Good cause circumstances are evaluated by the Commissioner or his/her designee in accordance with §17b-61 of the Connecticut General Statutes. The Agency's decision to grant an extension is final and is not subject to review or appeal.

The appeal should be filed with the clerk of the Superior Court in the Judicial District of New Britain or the Judicial District in which the Appellant resides.