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

[redacted]
Signature Confirmation

Client ID # 0[redacted]
Request # [redacted]

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted], the Department of Social Services (the "Department") sent [redacted] (the "Applicant") a Notice of Action ("NOA) informing her that she must pay $2144.55 in applied income towards her cost of care under the Long Term Care Medical Assistance program beginning [redacted].

On [redacted], the Applicant's son and Power of Attorney ("POA"), (the "Appellant") requested an administrative hearing to contest the Department's calculation of the applied income amount.

On [redacted], the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted].

On [redacted] in accordance with sections 17b-60, 17-61 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], the Appellant, POA for his mother, the Applicant, [redacted]
Andrew Pascarelli, DSS Hearing Liaison, Stamford Office via telephone conference fall
Elizabeth Clark, Eligibility Services Specialist, DSS New Haven Office
Maureen Foley-Roy, Hearing Officer

The hearing record remained open for the submission of additional evidence. On [redacted], the hearing record closed.

STATEMENTS OF THE ISSUE

The issue to be decided is whether the Department's determination that the Applicant must pay applied income of $2,144.55 per month was correct.

FINDINGS OF FACT

1. In [redacted], the Applicant was living alone in her co-op. Because she could no longer care for herself, the family decided that they would sell the Applicant's co-op and she would move in with her son, the Appellant and his family. (Appellant's testimony)

2. On [redacted], the Applicant fell and required a move to a skilled nursing facility. There was also a fire at the co-op she owned, which caused delays in their plans to sell as they had to make repairs. (Appellant's testimony)

3. When the Applicant entered the facility, it was unknown whether or not the placement would be permanent. There is no evidence in the record that the Applicant's stay would be short term and she did not return to the community. (Appellant's testimony and hearing record)

4. The Applicant had co-op expenses of $475 per month, in addition to the utility expenses at the co-op. The expenses continued after she moved out in [redacted] until the time the Co-Op was sold in [redacted]. (Appellant's exhibit 5: [redacted] invoice and Appellant's testimony)

5. On [redacted], the Department received an application for Medicaid for Long term care. (Exhibit L: Case Notes and Exhibit M: Application)

6. The Appellant did not include the private insurance premium amount information or verification on the application. (Exhibit M)

7. On [redacted], Department staff spoke with the Appellant who advised them that the Applicant had been admitted for a short term stay to a nursing facility and that she would need a rental diversion to assist with the expenses associated with her Co-op. (Exhibit L)

8. The Applicant receives Social Security benefits in the amount of $1446.00 per month. (Exhibit B: Notice of Action dated [redacted] and Appellant's testimony)

9. The Applicant receives a private pension of $800.95 per month. (Exhibit I: Provident Life and Accident Insurance Company Retirement Cerficate)

10. The Applicant's is on Medicare. Her Medicare A and B premiums are paid by the Department. The Applicant pays $42.40 each month for Medicare D. the Applicant also pays United Health Care for medical insurance. (Exhibit B: Notice of Action and Exhibit L)

11. On [redacted], the Applicant's Co-op was sold and the Applicant received the proceeds of $54,583.20, which has been deposited to and remains in an account. (Appellant's exhibit 3: Settlement documents and Appellant's testimony)

12. On [redacted], the Department sent a W1348 Proofs We Need form to the Appellant requesting proof of medical expenses, proof the United Health Care premium and proof of the sale of the home by [redacted] 2018. (Exhibit A: W1348 sent [redacted])

13. On [redacted], the Department granted HUSKY C Long Term Care assistance effective [redacted]. The Department calculated the applied income without having the premium amount for the private health insurance and determined that the Applicant must pay $2,144.55 towards the cost of her care each month effective [redacted]. (Exhibit B)

14. On [redacted], the Department received a completed W1685 form regarding the private health insurance but did not receive verification of the premium amount. (Exhibit K: Case Documents printout and Exhibit J: W1685)

15. On [redacted], the Department sent a Worker Generated Request for proofs requesting verification of the proceeds of the home and proof of monthly premium amount paid to United Health Care. (Exhibit F: W1348 Request dated [redacted] 2018)

16. On [redacted], the Department sent the Appellant a notice advising that the Applicant must pay $2,185.55 for her cost of care beginning in [redacted]. (Exhibit C: DSS notice dated [redacted])

17. In [redacted], the Applicant's Social Security benefit increased to $1487 per month. (Exhibit G2: LTSS Liability printout [redacted])

CONCLUSIONS OF LAW

1. Section 17b-2, section (9) of the Connecticut General Statutes, designates the Department of Social Services as the state agency for the administration of the

Medicaid program pursuant to Title XIX of the Social Security Act.

2. Uniform Policy Manual ("UPM") § 5045.20 provides that assistance units who are residents of Long Term Care Facilities (LTCF) or receiving community based services (CBS) are responsible for contributing a portion of their income toward the cost of their care.

3. 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 received.

4. The Department was correct when it determined the Applicant must pay applied income to the facility beginning in [redacted].

5. 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.

6. UPM § 5045.20 (B)(1)(b) provides for the amount of income to be contributed in LTCF cases and states 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.

7. 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, and 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 ("PNA") 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;(note: prior to July 2011, the PNA was $69 per month; in July of 2011, the PNA was reduced to $60)

    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.

8. UPM § 5035.20 B 7 a and b provides that the cost of maintaining a home in the community for the assistance unit is allowed as a monthly deduction from the income of an assistance unit in a LTCF **subject to the conditions that the amount is not deducted for more than six months and the likelihood of the institutionalized individual's returning to the community within six months is certified by a physician.** (Emphasis added)

9. Beginning in [redacted] the Applicant was entitled to the personal needs allowance of $60 per month and was also entitled to deduct the cost of her Medicare D premium.

10. The Department was correct when it determined that the Applicant must pay $2144.55 in applied income beginning in [redacted]. ($1446 (Soc.Sec) + $800.95 (pension) = $2246.95 - $60(PNA)-$42.40 Medicare D premium)

11. The Department was correct when it determined that the Applicant must pay $2185.45 in applied income beginning in [redacted]. ($1487 (Soc.Sec) + $800.95 (pension) = $2246.95 - $60(PNA)-$42.40 Medicare D premium)

DISCUSSION

The regulations are clear in that a Medicaid recipient who is residing in a long term care facility must contribute to the cost of his or her care. This is referred to as "applied income." In calculating the amount of that contribution, the regulations allow for deductions based on specific conditions. The Department allowed the

standard personal needs allowance and the premium that the Applicant was paying for Medicare D. The Department had requested proof of another insurance premium but had not received such proof and correctly did not allow the deduction. The regulations also allow a deduction for maintaining a home in the community for a period of six months if a physician certified that the Applicant is expected to return to the community within six months. There was no certification from a physician that the Applicant was likely to return to the community within six months. Testimony at the hearing indicated that the Applicant's condition was declining and it was unknown when she entered the facility whether or not it would be a permanent placement. The Applicant did not return to the community within six months. In the meantime, the Applicant's condo was sold and she received the proceeds from the sale.

At the time of the hearing, the Applicant's eligibility was in question due to the outstanding issues with the assets and proceeds of the sale. The Appellant did provide proof of the Applicant's other insurance premiums and the Department was prepared to make changes going forward.

DECISION

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

Maureen Foley-Roy

Maureen Foley-Roy
Hearing Officer

CC: Rachel Anderson, Cheryl Stuart, Lisa Wells, Operations Managers
DSS #20, New Haven
Noel Lord, Andrew Pascarelli, Hearing Liaisons, DSS, Stamford

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 Administrative Hearings and Appeals, 55 Farmington Avenue, Hartford, CT 06105-3725..

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, provided that the petition for reconsideration was filed timely with the Department. 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 the Commissioner's 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.