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

[REDACTED] 2019
Signature Confirmation

Client ID # [REDACTED]
Request # 135437

NOTICE OF DECISION

PARTY

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

PROCEDURAL BACKGROUND

The Department of Social Services (the "Department") sent [REDACTED] (the "Appellant") a Notice of Action ("NOA") granting Medicaid under the Long Term Care ("LTC") program effective [REDACTED] 2018 and informing her she must contribute toward the cost of convalescent care while a resident of the nursing facility.

On [REDACTED] 2019, the Appellant requested an administrative hearing to contest the Department's calculation of applied income.

On [REDACTED] [REDACTED] 2019, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [REDACTED] 2019.

On [REDACTED] 2019, 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], Authorized Representative for the Appellant
Leigh Hunt, Department Representative
Michael Briggs, Department Representative
Glenn Guerrera, Regional Office Representative
Lisa Nyren, Fair Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department correctly calculated the amount of income the Appellant must pay toward her cost of care while a resident of a nursing facility under the Medicaid LTC program.

FINDINGS OF FACT

1. The Appellant owned a three story condominium where she resided by herself prior to her admission to [redacted] (the "facility"), a skilled nursing facility. (Hearing Record)

2. On [redacted], 2018, the facility admitted the Appellant to their facility for a short term stay. (Exhibit 1: Long-term Care/Waiver Application and Exhibit A: Hearing Request)

3. The Department determined the Appellant eligible for Medicaid under the long term care program effective [redacted] 2018. (Department Representative's Testimony)

4. The Appellant expected to return to her condominium upon discharge from the facility. But due to safety issues of a multi-level home, the Appellant sought alternate community housing. (Exhibit A: Request for Hearing, Exhibit B: Authorized Representative's Statement, and Authorized Representative's Testimony)

5. In [redacted] 2018, the Appellant placed her condominium up for sale. (Department Representative's Testimony and Exhibit B: Authorized Representative's Statement)

6. On [redacted] 2018, the Appellant's physician wrote a letter on behalf of the Appellant. The physician wrote, "The anticipated discharge for [the Appellant] will be within six months. (Exhibit A: Physician's Letter)

7. Residents residing in a skilled nursing facility receiving Medicaid must pay a portion of their income known as applied income toward their cost of care. (Department Representative's Testimony)

8. The Appellant receives gross Social Security ("SSA") benefits of 1,331.00 per month. (Department Representative's Testimony)

9. Beginning [redacted] 2019, the Appellant's gross SSA benefits increased to $1,368.00 per month. (Department Representative's Testimony)

10. The Appellant pays $134.00 per month for Medicare Part B. (Exhibit 1: Long-term Care/Waiver Application)

11. Beginning [redacted] 2018, the Appellant receives assistance under the Medicare Savings Program ("MSP") in which the Department pays the Medicare Part B monthly premium on behalf of the Appellant. (Department Representative Testimony)

12. The Appellant pays $3.29 per week for employer sponsored dental insurance. (Exhibit 2: Medical Bills)

13. The Appellant incurred the following medical bills totaling $5,326.49 for which she is responsible to pay: (Exhibit 2: Medical Bills, Department Representative's Testimony and AREP's Testimony)

Medical Provider	Amount of Bill	Dates of Service
[redacted]	$2,387.00	[redacted] 2018
[redacted]	$1,720.00	Undetermined
[redacted]	$325.00	Undetermined
[redacted]	$510.00	[redacted], 2018
[redacted]	$325.00	[redacted] [redacted], 2018
[redacted]	$15.00	[redacted] [redacted] 2018
[redacted]	$15.00	[redacted] [redacted] 2018
[redacted]	$15.00	[redacted] [redacted] 2018
[redacted]	$14.49	[redacted] 2018
Total Unpaid Medical Bills	$5,326.49	

14. The Appellant's condominium expenses include utilities $754.50 per month, property taxes $288.17 per month, homeowner's insurance $212.00 per month, and condominium fees $275.00 per month. (Exhibit 1: Long-term Care/Waiver Application)

15. On [redacted] 2019, the facility discharged the Appellant to her new apartment in the community. (AREP's Testimony)

16. On [redacted] 2019, the Appellant sold the condominium where she resided prior to her admission to the facility. (AREP's Testimony)

17. The Appellant received the following monthly deductions to calculate the amount of income she must pay to her monthly cost of care:

    Personal Needs Allowance ("PNA"): $60.00
    Medicare Part B premium: $134.00
        $134.00 [redacted] 2018
        $134.00 [redacted] 2018
        $134.00 [redacted] 2018

Health Insurance Premium (dental): $14.15 ($3.29/week x 4.3 weeks)
Out of Pocket Medical Expenses Total: $5,326.49
$1,122.85 [redacted] 2018
$1,122.85 [redacted] 2018
$1,122.85 [redacted] 2018
$1,256.85 [redacted] 2018
$701.09 [redacted] 2019

18. The Department did not allow a deduction to the applied income for the cost of maintaining a home in the community because the Appellant placed her condominium up for sale. (Department Representative's Testimony)

19. For the period [redacted] 2018 through [redacted] 2018, the Department determined the Appellant's contribution toward her cost of care at the facility as $00.00 per month: (Hearing Record)

Gross Income	$1,331.00
Minus PNA	- $60.00
Minus Medicare Part B Premium	-$134.00
Minus Dental Insurance Premium	-14.15
Equals	$1,122.85
Minus Diversion for Outstanding Medical Bills	-$1,122.85
Applied Income	$00.00

20. For [redacted] 2018, the Department determined the Appellant's contribution toward her cost of care at the facility as $00.00: (Hearing Record)

Gross Income	$1,331.00
Minus Personal Needs Allowance	-60.00
Minus Dental Insurance Premium ($3.29/week x 4.3 weeks)	-14.15
Equals	$1,256.85
Minus Diversion for Outstanding Medical Bills	-$1,256.85
Applied Income	$00.00

21. For [redacted] 2019, the Department determined the Appellant's contribution toward her cost of care at the facility as $592.76: (Hearing Record)

Gross Income	$1,368.00
Minus Personal Needs Allowance	-60.00
Minus Dental Insurance Premium ($3.29/week x 4.3 weeks)	-14.15
Equals	$1,293.85
Minus Diversion for Outstanding Medical Bills	-$701.09
Applied Income	$592.76

22. For [redacted] 2019, the Department determined the Appellant's contribution toward her cost of care at the facility as $1,293.85:

Gross Income	$1,368.00
Minus Personal Needs Allowance	-60.00
Minus Dental Insurance Premium ($3.29/week x 4.3 weeks)	-14.15
Equals	$1,293.85

CONCLUSIONS OF LAW

1. Connecticut General Statute ("Conn. Gen. Stats.") § 17b-2(6) provides that the Department of Social Services is designated as the state agency for the administration of the Medicaid program pursuant to Title XIX of the Social Security Act.

2. State statute provides that the Department of Social Services shall be the sole agency to determine eligibility for assistance and services under programs operated and administered by said department. [Conn. Gen. Stat. § 17b-261b(a)]

3. State statute provides that for purposes of this section, "applied income" means the income of a recipient of medical assistance, pursuant to section 17b-261, that is required, after the exhaustion of all appeals and in accordance with state and federal law, to be paid to a nursing home facility for the cost of care and services. [Conn. Gen. Stat. § 17b-261r(a)]

4. State statute provides that in determining the amount of applied income, the Department of Social Services shall take into consideration any modification to the applied income due to revisions in a medical assistance recipient's community spouse minimum monthly needs allowance, as described in Section 1924 of the Social Security Act, and any other modification to applied income allowed by state or federal law. [Conn. Gen. Stat. § 17b-261r(b)]

5. Title 42 of the Code of Federal Regulations ("CFR") § 436.832(a)(1) provides that the agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section from the individual's total income.

   Uniform Policy Manual ("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. 42 CFR § 436.832(a)(2) provides the individual's income must be determined in accordance with paragraph (e) of this section.

   42 CFR § 436.832(e)(1) provides in determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received or it may project total monthly income for a prospective period not to exceed 6 months.

   UPM § 5050.13(A)(1) provides that income from these sources [Social Security and Veterans' Benefits] is treated as unearned income in all programs.

7. 42 CFR § 436.832(a)(3) provides that medical expenses must be determined in accordance with paragraph (f) of this section.

   42 CFR § 436.832(f)(1) provides that in determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expense for a prospective period not to exceed 6 months.

8. 42 CFR § 436.832(b) provides that this section applies to medically needy individuals in medical institutions and intermediate care facilities.

9. 42 CFR § 436.832(c) provides that the agency must deduct the following amounts, in the following order, from the individual's total income as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.

   1. *Personal needs allowance.* A personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution. This protected personal needs allowance must be at least-
      i. $30 a month for an aged, blind, or disabled individual , including a child applying for Medicaid on the basis of blindness or disability;
      ii. $60 a month for an institutionalized couple if both spouses are aged, blind, or disabled and their income is considered available to each other in determining eligibility; and
      iii. For other individual, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, or disabled.
   2. *Maintenance needs of spouse.* For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the higher of-

- i. The amount of the highest need standard for an individual without income and resources under the State's approved plan of OAA, AFDC, AB, APTD, or AABD; or
- ii. The amount of the highest medically needy income standard for one person established under § 436.811.

3. *Maintenance needs of family.* For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must-
   - i. Be based on a reasonable assessment of their financial need;
   - ii. Be adjusted for the number of family members living in the home; and
   - iii. Not exceed the highest of the following need standards for a family of the same size:
     - A. The standard used to determine eligibility under the State's Medicaid plan, as provided for in §436.811.
     - B. The standard used to determine eligibility under the State's approved AFDC plan.
4. *Expenses not subject to third party payment.* Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including-
   - i. Medicare and other health insurance premiums, deductibles, or coinsurance charges; and
   - ii. Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

10. 42 CFR § 436.832(d) *Optional deduction: Allowance for home maintenance.* For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if-

    1. The amount is deducted for not more than a 6-month period; and
    2. A physician has certified that either of the individuals is likely to return to the home within that period.

11. UPM § 5035.20(A) provides that the deductions described below are subtracted from income:

    1. Beginning with the month in which the 30th day of continuous LTCF care or the receipt of community-based services occurs; and
    2. Ending with the month in which the unit member discharged from the LTCF or community-based services are last received.

12. 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 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.
7. The cost of maintaining a home in the community for the assistance unit, subject to the following conditions:
   a. The amount is not deducted for more than six months; and
   b. The likelihood of the institutionalized individual's returning to the community within six months is certified by a physician; and
   c. The amount deducted is the lower of either:
      1. The amount the unit member was obligated to pay each month in his or her former community arrangement; or
      2. $650.00 per month if the arrangement was Level 1 Housing; or
      3. $400 per month if the arrangement was level 2 Housing; and
   d. The amount deducted includes the following:
      a. Heat
      b. Hot water
      c. Electricity
      d. Cooking fuel

e. Water
f. Laundry
g. Property taxes
h. Interest on the mortgage
i. Fire insurance premiums
j. amortization

13. State statute provides that effective July 1, 2011; the Commissioner of Social Services shall permit patients residing in nursing home, chronic disease hospitals and state human institutions who are medical assistance recipients under sections 17b-260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, and 17b-357 to 17b-351, inclusive to have a monthly personal fund allowance of sixty dollars.

14. UPM § 4520.15(C)(1)(a) defines Level 1 Housing. An applicant or recipient is considered to be living in Level 1 Housing in the following situations:

    1. He or she is living in commercial housing or in a Department of Mental Health (DMH) sanctioned supervised apartment and not sharing a bedroom with any other individual;
    2. He or she is living in a shelter for the homeless or for battered women;
    3. He or she is living in any type of housing not mentioned in (1) or (2) above, and is not sharing his or her bedroom, bathroom or kitchen with another individual.

15. The Department correctly determined the Appellant's gross monthly income as $1,331.00 per month for the period [REDACTED] 2018 through [REDACTED] 2018.

16. The Department correctly determined the Appellant's gross monthly income as $1,368.00 per month beginning [REDACTED] 2019.

17. The Department correctly allowed the Personal Needs Allowance ("PNA") of $60.00 as a qualifying deduction from the Appellant's income.

18. For the months of [REDACTED] 2018, [REDACTED] 2018, and [REDACTED] 2018, the Department correctly allowed the Medicare Part B premium as a qualifying deduction of $134.00 from the Appellant's income.

19. The Department correctly allowed the monthly dental insurance premium of $14.15 from the Appellant's income.

20. The Department correctly allowed the cost of medical treatment incurred by the Appellant prior to Medicaid eligibility as a qualifying deduction from the Appellant's income.

21. For the months [redacted] 2018, [redacted] 2018, and [redacted] 2018, the Department correctly calculated the monthly cost of care as $00.00. ($1,331.00 gross monthly income - $60.00 PNA -$134.00 Medicare Part B monthly premium - $14.15 Monthly Dental Insurance Premium - $1,122.85 incurred medical expenses = $00.00)

22. For [redacted] 2018, the Department correctly calculated the monthly cost of care as $00.00. ($1,331.00 gross monthly income - $60.00 PNA - $14.15 Monthly Dental Insurance Premium - $1,256.85 incurred medical expenses = $00.00)

23. The Department incorrectly determined the Appellant ineligible for an allowance for home maintenance. The cost of maintaining a home in the community is a qualifying deduction in the determination of applied income when a physician has certified that the individual is likely to return to the community within with six months. The Appellant's physician provided a letter indicating she was expected to return to the community in under six months. Testimony provided at the hearing stated the Appellant expected to return to the community. Although the Appellant placed her condominium on the market, she remained responsible for the expenses of maintaining the home in the community whether or not the home was listed for sale. The Appellant is eligible for a deduction due to the cost of maintaining a home in the community.

24. The Appellant's condominium is level 1 housing and entitled to a maximum deduction of $650.00 under the cost of maintaining a home in the community deduction.

25. For [redacted] 2019, the Department incorrectly calculated the monthly cost of care as $592.76. The correct applied income is $00.00. Department policy states applied income begins with the month in which the 30th day of continuous LTCF care begins and the Appellant's 30th day of continuous LTCF is [redacted], 2018. The six month period for which the Appellant may qualify for the cost of maintaining a home in the community is [redacted] 2018 through [redacted] 2019. Regulation provides for the specific order in which qualifying deductions are considered. The Appellant's eligibility for a deduction for the cost of maintaining a home in the community is subtracted after the PNA, medical insurance premiums, and medical expenses leaving [redacted] as the only month of eligibility for such a deduction. ($1,368.00 gross income - $60.00 PNA - $14.15 Dental Insurance Premium - $701.09 incurred medical expenses remaining balance - $650.00 Level 1 Housing = $(-57.24))

26. For ██████ 2019, the Department correctly calculated the monthly cost of care as $1,293.85. ($1,368.00 gross income - $60.00 PNA - $14.15 Dental Insurance Premium = $1,293.85)

DECISION

The Appellant's appeal is in part denied and in part granted.

ORDER

1. The Department must apply the deduction for maintaining a home in the community in the amount of $650.00 for ██████ 2019 and correct the applied income for January 2019 from $592.76 to $00.00.

2. Compliance is due within 10 days from the date of this decision.

Lisa A. Nyren
Fair Hearing Officer

CC: Fred Presnick, DSS RO #30
Yecenia Acosta, DSS RO #30
Tim Latifi, DSS RO #30
Leigh Hunt, DSS RO #30
Michael Briggs, DSS RO #30
██████████, Power of Attorney

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.

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.