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

2022
Signature Confirmation

Case #
Client ID #
Request # 200646

NOTICE OF DECISION
PARTY

PROCEDURAL BACKGROUND

On 2022, the Department of Social Services (the "Department") sent (the "Appellant") a Notice of Action ("NOA") stating that he was approved for Husky C – Long Term Care Medicaid Coverage for Facility Residents Eligible Under Special Income Level ("L01") and he must pay $1,096.00 each month in Patient Liability Amount ("PLA"), also known as Applied Income ("AI") towards the cost of his long term care effective 2022.

On 2022, the Appellant requested an Administrative Hearing to contest the Department's calculation of the AI amount.

On 2022, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a Notice scheduling the Administrative Hearing for 2022.

On [REDACTED] 2022, 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 telephonically.

The following individuals participated by phone:

[REDACTED] Appellant
[REDACTED] [REDACTED], Business Officer Manager
Elizabeth Clark, Department's Representative
Jessica Gulianello, Hearing Officer

The Hearing Record remained open to allow both parties time to submit additional information. Additional documents were received and on [REDACTED] 2022, the hearing record closed accordingly.

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department correctly calculated the AI amount that the Appellant is responsible to pay toward the cost of his long-term care and if the effective start date of [REDACTED] 2022, is correct.

FINDINGS OF FACT

1. The Appellant was a resident of [REDACTED] ("[REDACTED]") prior to his admission to the current [REDACTED] ("[REDACTED]") facility. (Hearing Record)

2. The Appellant was responsible to pay an out-of-pocket fee in the amount of $[REDACTED] per month to the [REDACTED] that included the costs associated with his meals, medication, and room and board. (Appellant's Testimony)

3. The Appellant was hospitalized from [REDACTED] 2022, until [REDACTED] 2022, due to [REDACTED]. (Exhibit 4: Assessment Pro).

4. On [REDACTED] 2022, the Appellant was discharged from the hospital and admitted to the [REDACTED] facility, [REDACTED] (the "Facility"). (Exhibit 4: Assessment Pro, Hearing Record)

5. On [REDACTED] 2022, the Appellant was permanently discharged from the [REDACTED]. (Exhibit 5: Report of Admission or Discharge ("W-265"), signed [REDACTED]/2022, Department's Testimony)

6. The Appellant was initially admitted to the Facility for a short-term stay. The Facility subsequently updated the Appellant's status to a long-term stay in [REDACTED] of 2022. (Exhibit 4: Assessment Pro, Facility Testimony)

7. On [redacted] 2022, the Department updated the Appellant's address and living arrangement in their online eligibility system, "ImpaCT". ImpaCT issued the Appellant a NOA. The NOA informed the Appellant that the Medicaid under the Husky C – Aged, Blind, Disabled and receiving State Supplement Cash ("S01") was closed effective [redacted] 2022. The NOA also informed the Appellant that he was approved for L01 LTC Medicaid effective [redacted] 2022, with an AI liability of $1,096 per month effective [redacted] 2022. (Exhibit 8: NOA, [redacted]/2022, Department's Testimony)

8. The Appellant is [redacted] years old (D.O.B [redacted]). (Appellant's Testimony)

9. The Appellant is [redacted]. (Appellant's Testimony)

10. The Appellant is a recipient of [redacted] benefits ("[redacted]") from the Social Security Administration in the amount of $1,171 per month. (Hearing Record)

11. The Appellant does not own a home in the community. (Appellant's Testimony)

12. The Appellant does not incur out-of-pocket medical expenses. (Appellant's Testimony)

13. The Appellant is a recipient of the Qualified Medicare Beneficiary ("MSP"). The MSP pays for his Medicare Part B premium. (Exhibit 8: NOA, [redacted]/2022)

14. The Applicant's PLA (AI) was calculated as follows:

Gross Income	$1,171 [redacted] benefits
Minus (-) Personal Needs Allowance ("PNA")	$75.00 Standard deduction for residents of skilled nursing facilities ("SNF")
Minus (-) Monthly Out-of-Pocket Medical Expenses	$0 Liability
Equals PLA (AI)	**$1,096.00 per month**

(Exhibit 8: NOA, [redacted]/2022, Department's Testimony)

17. The issuance of this decision is timely under Connecticut General Statutes 17b-61(a), which requires that a decision be issued within 90 days of the request for an administrative hearing. The Appellant requested an Administrative Hearing on ██████ 2022. This decision, therefore, was due no later than ██████ 2022. However, the Hearing Record which had anticipated to close on ██████ 2022, did not close for the admission of evidence until ██████ 2022. Because this ██-day delay in the close of the record arose from the request of the Appellant, this final decision was not due until ██████ 2022, and is therefore timely. (Hearing Record)

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)]

   The Department has the authority to administer Medicaid.

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)]

   The Department correctly determined AI is the income the Appellant is required to pay to the Facility for the cost of his care and services.

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)]

   The Department correctly determined that the Appellant is ██████ and therefore he does not have a community spouse.

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.

6. "The department's uniform policy manual is the equivalent of a state regulation and, as such, carries the force of law." Bucchere v. Rowe, 43 Conn. Supp. 175, 178 (1994) (citing Conn. Gen. Stat. § 17b-10; Richard v. Commissioner of Income Maintenance, 214 Conn. 601, 573 A.2d 712 (1990)

   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.

7. 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.

   The Department correctly determined that the Appellant's ████ benefits in the amount of $1,171 per month are treated as countable ████████ income.

8. 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.

   The Department correctly determined that the Appellant does not incur any out-of-pocket medical expenses.

9. 42 CFR § 436.832(b) provides that this section applies to medically needy individuals in medical institutions and intermediate care facilities.

10. 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.

11. 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.

The Department correctly determined the Appellant was eligible for the PNA disregard.

The Department correctly determined that the remaining abovementioned deductions are not applicable to the Appellant.

12. 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.

    The Department correctly determined the Appellant's 30th day of continuous LTC care at the Facility was in ███ 2022.

13. 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

The Department correctly allowed the current PNA of $75 as a qualifying deduction from the Appellant's income.

DISCUSSION

The Appellant provided a list of personal items he purchased after his admission to the Facility. The Appellant did not provide receipts to verify the purchases. Furthermore, I find the purchases are not allowable deductions with respect to the calculation of the AI amount.

The Facility argued for hardship consideration. Undue hardship conditions exist when an individual would be in danger of losing payment for LTC or equivalent services solely because of the imposition of a penalty period. The Department did not impose a penalty; therefore, I find the Facility's argument to be invalid.

DECISION

The Appellant's appeal is DENIED.

Jessica Gulianello

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Jessica Gulianello
Hearing Officer

CC: Elizabeth Clark, ESS DO 20, Rachael Anderson, SSOM, DO 20, Matthew Kalarickal, SSOM, DO 20, Lisa Wells, SSOM, DO 20

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 §4-1181a (a) of the Connecticut General Statutes.

Reconsideration requests should include specific grounds for the request: for example, indicate what error of fact or law, 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 with 45 days of the mailing of this decision, or 45 days after the agency denies 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 fooled at Superior Court. A copy of the petition must be served upon the Office of the Attorney General, 165 Capitol Avenue, Hartford, CT 06106 or the Commissioner of the Department of Social Services, 55 Farmington Avenue, Hartford, CT 06105-3725. 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 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.