September 25, 2024

[redacted]

RE: [redacted] v. DoHS/BFA
ACTION NO.: 24-BOR-2929

Dear [redacted]:

Enclosed is a copy of the decision resulting from the hearing held in the above-referenced matter.

In arriving at a decision, the State Hearing Officer is governed by the Public Welfare Laws of West Virginia and the rules and regulations established by the Department of Human Services. These same laws and regulations are used in all cases to assure that all persons are treated alike.

You will find attached an explanation of possible actions you may take if you disagree with the decision reached in this matter.

Sincerely,

Kristi Logan
Certified State Hearing Officer
Member, State Board of Review

Encl: Recourse to Hearing Decision
Form IG-BR-29

cc: Erin Nelson, [redacted] DoHS

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 24-BOR-2929**

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES
BUREAU FOR FAMILY ASSISTANCE,

Respondent.

DECISION OF STATE HEARING OFFICER

INTRODUCTION

This is the decision of the State Hearing Officer resulting from a fair hearing for [redacted] This hearing was held in accordance with the provisions found in Chapter 700 of the Office of Inspector General Common Chapters Manual. This fair hearing was convened on September 18, 2024.

The matter before the Hearing Officer arises from the July 16, 2024, determination by the Respondent of the Appellant's monthly contribution for Long Term Care Medicaid.

At the hearing, the Respondent appeared by Erin Nelson, [redacted] County DoHS. The Appellant appeared by his wife, [redacted]. The witnesses were placed under oath and the following documents were admitted into evidence.

Department's Exhibits:

D-1 Application for Long Term Care Medicaid dated April 16, 2024
D-2 Notices of Approval dated July 16, 2024
D-3 Paystubs for [redacted] dated March 15, March 29, April 12, and April 26, 2024
D-4 Income Summary Screen
D-5 Long Term Care Budget Screen
D-6 West Virginia Income Maintenance Manual §24.7.3.A
D-7 Case Comments from April through August 2024

Appellant's Exhibits:

None

After a review of the record, including testimony, exhibits, and stipulations admitted into evidence at the hearing, and after assessing the credibility of all witnesses and weighing the evidence in consideration of the same, the Hearing Officer sets forth the following Findings of Fact.

FINDINGS OF FACT

1) The Appellant was admitted to a nursing facility on April 11, 2024 (Exhibit D-7).

2) The Pre-Admission Screening form dated April 5, 2024, documented that the Appellant would not return home (Exhibit D-7).

3) An application for Long Term Care Medicaid was submitted to the Respondent by the Appellant's wife, [redacted], on April 16, 2024 (Exhibit D-1).

4) [redacted] reported the Appellant's income as $1,846.60 a month in Social Security Disability benefits and earned income for herself (Exhibit D-1).

5) [redacted] reported that the Appellant paid his Medicare premium of $274.30 per month (Exhibit D-1).

6) The Respondent calculated [redacted] monthly earned income as $4,072.54 based on paystubs provided (Exhibits D-3 and D-7).

7) The Respondent verified the Appellant's monthly Medicare premium as $209.60 through the State Online Query (SOLQ) system (Exhibit D-7).

8) The Appellant was given income deductions for his personal needs allowance and the Medicare premium (Exhibits D-5).

9) The Respondent determined the Appellant's monthly contribution for his cost of care at the nursing facility for April 2024 as $1,058 and for May 2024 and ongoing as $1,587 (Exhibits D-2).

10) On August 1, 2024, [redacted] contacted the Respondent regarding the Appellant's monthly contribution amount (Exhibit D-7).

11) [redacted] reported that additional money exceeding the $209.60 Medicare premium amount was deducted from the Appellant's Social Security benefits (Exhibit D-7).

12) [redacted] provided verification to the Respondent that a health insurance premium of $115.80 was being deducted from the Appellant's monthly Social Security benefits in addition to the Medicare premium (Exhibit D-7).

13) [redacted] also submitted outstanding medical bills for the Appellant totaling $6,153.74 (Exhibit D-7).

14) The Appellant's monthly contribution was reduced to $0 from September through December 2024 (Exhibit D-7).

15) The Appellant's monthly contribution will be $268.94 for January 2025 and will increase to his ongoing monthly amount of $1,471.21 effective February 2025.

APPLICABLE POLICY

Code of Federal Regulations 42 §735.25 explains the application of patient income to the cost of care:

(a) ***Basic rules.***
(1) 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,
(2) The individual's income must be determined in accordance with paragraph (e) of this section.
(3) Medical expenses must be determined in accordance with paragraph (f) of this section.
(b) ***Applicability.*** This section applies to the following individuals in medical institutions and intermediate care facilities.
(1) Individuals receiving cash assistance under SSI or AFDC who are eligible for Medicaid under §435.110 or §435.120.
(2) Individuals who would be eligible for AFDC, SSI, or an optional State supplement except for their institutional status and who are eligible for Medicaid under §435.211.
(3) Aged, blind, and disabled individuals who are eligible for Medicaid, under §435.231, under a higher income standard than the standard used in determining eligibility for SSI or optional State supplements.
(c) ***Required deductions.*** In reducing its payment to the institution, 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 individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and 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 highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;
(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement beneficiaries under §435.230; or
(iii) The amount of the medically needy income standard for one person established under §435.811, if the agency provides Medicaid under the medically needy coverage option.
(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 higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under §435.811, if the agency provides Medicaid under the medically needy coverage option for a family of the same size.
(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.
(5) ***Continued SSI and SSP benefits.*** The full amount of SSI and SSP benefits that the individual continues to receive under sections 1611(e)(1) (E) and (G) of the Act.
(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.
(3) 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—
(i) The amount is deducted for not more than a 6-month period; and
(ii) A physician has certified that either of the individuals is likely to return to the home within that period.
(e) ***Determination of income*** —
(1) ***Option.*** 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 monthly income for a prospective period not to exceed 6 months.
(2) ***Basis for projection.*** The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.
(3) ***Adjustments.*** At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) ***Determination of medical expenses*** —
(1) ***Option.*** 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 expenses for a prospective period not to exceed 6 months.
(2) ***Basis for projection.*** The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and on medical expenses expected to be incurred.
(3) ***Adjustments.*** At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

West Virginia Income Maintenance Manual Chapter 4 explains income eligibility determination for Medicaid:

4.6.1 Budgeting Method
Eligibility is determined on a monthly basis. Therefore, it is necessary to determine a monthly amount of income to count for the eligibility period. The following information applies to earned and unearned income. For all cases, the Worker must determine the amount of income that can be reasonably anticipated for the assistance group (AG). For all cases, income is projected*; past income is used only when it reflects the income the client reasonably expects to receive during the certification period.

4.6.1.A Methods for Reasonably Anticipating Income
There are two methods for reasonably anticipating the income the client expects to receive. One method uses past income and the other method uses future income. Both methods may be used for the same AG for the same certification period. The method used depends on the circumstances of each source of income. Use past income only when both of the following conditions exist for a source of income:

- Income from the source is expected to continue into the certification period or POC.
- The amount of income from the same source is expected to be more or less the same. For these purposes, the same source of earned income means income from the same employer, not just the continued receipt of earned income

4.6.1.B Consideration of Past Income
The Worker must consider information about the client's income sources before deciding which income to use. The Worker must follow the steps below for each old income source.

- Step 1: Determine the amount of income received by all persons in the Income Group (IG) in the 30 calendar days prior to the application/redetermination date. The appropriate time period is determined by counting back 30 days beginning with the calendar day prior to the date of application/redetermination. The income from this 30-day period is the minimum amount of income that must be considered. When, in the Worker's judgment, future income may be more reasonably anticipated by considering the income from a longer period of time, the Worker considers income for the time period he determines to be reasonable.

Whether the Worker considers income from the prior 30 days, or from a longer period of time, all of the income received from that source during that time period must be considered. All pay periods during the appropriate time period must be considered and must be consecutive.

- Step 2: Determine if the income from the previous 30 days is reasonably expected to continue into the new certification period or POC. If it is not expected to continue, the income from this source is no longer considered for use in the new certification period or POC. If it is expected to continue, determine if the amount is reasonably expected to be more or less the same. If the income is expected to continue, the income source is used for the new certification period or POC and treated according to How to Use Past and Future Income below. If it is not expected to continue at more or less the same amount, the income source is used for the new certification period or POC and treated according to Consideration of Future Income below.
- Step 3: Record the results of Step 2, including the amount of income, why the source is or is not being considered for the new certification period or POC, the client's statement about continuation of the income from this source, the time period used, and, if more than the previous 30 days, the reason additional income was considered.

4.6.1.D How to Use Past and Future Income

After the Worker determines all of the income sources that are to be considered for use, the Worker determines the amount of monthly income, based on the frequency of receipt and whether the amount is stable or fluctuates. This is described below.

*NOTE: The purpose of finding an average amount of fluctuating income is to even out the highs and lows in the amount of income. The client is not, then, required to report fluctuating income each pay period, and the Worker is not required to change income monthly. Should the client report fluctuations in the amount of income, the Worker is only required to recalculate the countable income when, in his judgment, the fluctuation will affect eligibility. All changes reported by the client must be considered, but not necessarily used. Reported changes must be recorded and the Worker must record why the reported income was or was not used.

Conversion of income to a monthly amount is accomplished by multiplying an actual or average amount as follows:

- Weekly amount x 4.3
- Biweekly amount (every two weeks) x 2.15
- Semimonthly (twice/month) x 2

West Virginia Income Maintenance Manual Chapter 24 explains eligibility for Long Term Care Medicaid:

24.7 Income for Eligibility Determination

There is a two-step income process for providing Medicaid coverage for nursing facility services to individuals in nursing facilities. The client must be eligible for Medicaid and there must be a determination to see if the client must contribute to the cost of care.

Medicaid eligibility can be established by virtue of being a Qualified Medicare Beneficiary (QMB) client, of being a member of a full Medicaid coverage group, by meeting a special income test for the nursing facility coverage group, or by meeting a SSI-Related/Monthly Spenddown. See Chapter 23 to determine which coverage groups provide full coverage Medicaid. Once Medicaid eligibility is established, if applicable, the client's contribution toward his cost of care in the facility is determined in the post-eligibility process. The post-eligibility process is described in Section 24.7.3 below.

24.7.2.C Nursing Facility Coverage Group, Gross Income Test

If the client is not currently eligible by having QMB or full coverage Medicaid, Medicaid eligibility may be established as follows:

- If the client's gross countable monthly income is equal to or less than 300% of the current maximum Supplemental Security Income (SSI) payment for one person and the client is institutionalized, he may be eligible.
- SSI-Related Categorical Medicaid requirements (aged, blind or disabled) and asset guidelines must be met. These clients' contribution toward cost of care is determined in the post-eligibility process. There is no spenddown amount for these clients.

24.7.3 Post-Eligibility Process

The post-eligibility process does not apply to the MAGI Medicaid coverage groups – Adult Group, Parents/Caretaker Relatives, Pregnant Women, Children Under Age 19, or certain QMB clients. MAGI Medicaid coverage groups and QMB clients for whom Medicare pays a full month do not contribute to the cost of their nursing facility care. Income sources that are excluded for the coverage group under which eligibility is determined are also excluded in the post-eligibility process for nursing facility services. See Section 4.3 for excluded sources for the appropriate coverage group. In determining the client's contribution toward his cost of nursing facility care, the Worker must apply only the income deductions listed below. This is the post-eligibility process. The remainder, after all allowable deductions, is the resource amount, which is at least part of the amount the client must contribute toward his cost of care. The client's spenddown amount, if any, as determined above, is added to the resource amount to determine the client's total contribution toward his nursing care, except when there is a community spouse. In cases with a community spouse, the spenddown is not added to the computed resource amount. The spenddown is used only to compare to the nursing facility's Medicaid cost of care to determine eligibility. See Section 24.7.6

24.7.3.A Income Disregards and Deductions

Only the items in the following sections may be deducted from the client's gross income in the post-eligibility process

24.7.3.A.1 Client's Personal Needs Allowance (PNA)

This amount is subtracted from income to cover the cost of clothing and other personal needs of the nursing facility resident. For most residents, the monthly amount deducted is $50. However, for an individual who is receiving the reduced Veterans Affairs (VA) pension of $90, the monthly PNA is $90. Similarly, an individual receiving SSI will have

his monthly allocation reduced to $30, which is his monthly PNA if he is in the facility for at least three months.

24.7.3.A.2 Community Spouse Maintenance Allowance (CSMA)

When the institutionalized individual has a spouse living in the community, a portion of his income may be deducted for the support of the spouse at home. The community spouse must be included as part of the case and his living expenses taken into consideration to calculate the CSMA. To determine the CSMA, the income of the community spouse is subtracted from a Spousal Maintenance Standard (SMS) which is either:

- The minimum SMS. This is 150% of the monthly FPL for 2 persons; or
- The minimum SMS, increased by excess shelter/utility expenses, but not exceeding the maximum SMS. See Chapter 4, Appendix A for the minimum and maximum Spousal Maintenance Standard amounts. The remainder is the amount of the institutionalized spouse's income which can be used to meet his community spouse's needs. For the deduction to be applied, the determined amount must actually be paid to the community spouse. If the client contributes less than the determined amount, only the amount actually contributed to the community spouse is deducted. If he has been ordered by a court or a Hearings Officer to contribute more to his spouse, the higher amount is deducted.

The following steps are used to determine the amount of the CSMA:

- Step 1: Add the actual shelter cost and the amount of the current SNAP Heating/Cooling Standard (HCS). See Chapter 4, Appendix B. The shelter cost must be for the home the institutionalized spouse and the community spouse shared prior to institutionalization, and in which the community spouse continues to live. It must have been the client's principal place of residence. Shelter costs include rent or mortgage payments, interest, principal, taxes, insurance and required maintenance charges for a condominium or cooperative.
- Step 2: Compare the total of the costs in Step 1 to 30% of the minimum SMS. See Chapter 4, Appendix A. When the shelter/utility costs exceed 30% of the minimum SMS, subtract the 30% amount from the shelter/utility costs.
- Step 3: Add the remainder from Step 2 to the minimum SMS. This amount, not to exceed the maximum SMS, is used in Step 5. See Chapter 4, Appendix A.
- Step 4: Add together the community spouse's gross, countable earned and unearned income.
- Step 5: Subtract the Step 4 amount from the amount determined in Step 3 and if there are any cents, round the resulting amount up. This is the amount subtracted from the income of the institutionalized spouse for the needs of his community spouse. If the Step 4 amount is equal to or greater than the Step 3 amount, no deduction is allowed. If the calculated CMSA is less than the minimum SMS or the Community Spouse will experience extreme financial duress, a fair hearing can be requested by the client, community spouse or authorized representative to obtain more of the institutionalized spouse's income and/or assets.

24.7.3.A.3 Family Maintenance Allowance (FMA)
When the institutionalized individual has family members who are living with the community spouse and who are financially dependent upon him, an FMA is deducted from his income. For purposes of this deduction, family members are the following people only: minor or dependent children, dependent parents of either spouse and dependent siblings of either spouse. This deduction is applied only when the institutionalized individual has a community spouse, and such family members live with the community spouse.

24.7.3.A.4 Outside Living Expense (OLE)
Single individuals and couples, when both spouses are institutionalized, receive a $175 deduction from income for maintenance of a home when a physician has certified in writing that the individual, or in the case of a couple, either individual, is likely to return to the home within six months. The amount may be deducted for up to six months. When both spouses are institutionalized, only one spouse may receive the OLE. They may choose which spouse receives the deduction. The OLE may be deducted during subsequent nursing facility admissions if the individual or couple meets the criteria listed above.

24.7.3.A.5 Non-Reimbursable Medical Expense (NRME)
Certain non-reimbursable medical expenses for the eligible client only may be deducted in the post-eligibility process. These expenses are sometimes referred to as "remedial expenses." Non-reimbursable means the expense will not be or has not been paid to the provider or reimbursed to the client by any third-party payer, such as, but not limited to, Medicare, Medicaid, private insurance or another individual. These allowable expenses are listed in Section 4.14.4.J.3. Incurred medical expenses, including nursing facility costs (except for nursing facility costs for clients with a community spouse), for which the client will not be reimbursed, are subtracted from his remaining income.

Clients Residing in a Nursing Facility
The request for consideration of a non-reimbursable medical expense must be submitted within one year of the date of service(s). Documentation must consist of the following:

- An order and statement of the medical necessity from a prescribing physician, dentist, podiatrist or other practitioner with prescribing authority under West Virginia law; and
- An itemization of the services provided. When the request to deduct non-reimbursable medical expenses originates from a nursing facility or is presented by the client as a bill from a nursing facility, a detailed itemization of the services must be provided. The itemization must include:
    - The date of the service or expense;
    - The specific medical service;
    - The reason no payment was received by the facility; and o The amount of the expense. Charges billed to Medicare, Medicaid or private insurance must be accompanied by an Explanation of Benefits (EOB) to be considered. Only charges denied because they are not covered services may be used.

24.7.4 First and Last Month Calculations

During the first month and last month in which Medicaid participates in the cost of care, the Worker must prorate the client's contribution to his cost of care when he does not spend the full calendar month in the facility. This policy applies only to the first and last months of nursing facility residence when Medicaid participates in the payment. It is not used when the client leaves the facility for other medical treatment, for family visits, etc. During all other months, the client must pay his full contribution and be reimbursed by the facility if an overpayment occurs. This proration is accomplished as follows:

- Determine the client's total monthly cost contribution amount as for any other nursing facility resident who expects to remain in the facility a full month.
- Divide the client's total monthly cost contribution by the actual number of days in the calendar month. This becomes the client's daily contribution rate, which is used for this purpose only.
- Determine the number of days the client resided or expects to reside in the facility in the calendar month. When the contribution is prorated for the last month of nursing facility residence, only days during which the client resides in the facility are calculated. Days during which the client does not reside in the facility, including bed-hold days, are not considered. Multiply the number of days by the daily contribution rate.
- The result is the client's total cost contribution for the partial month. After all computations have been completed, any cents calculated as part of the result are dropped. During the first month of Medicaid participation in the cost of care, when the client is not in the facility for a full month, if necessary, the Worker can calculate how much the client retains for his personal needs and how much is contributed to the community spouse and other family members as follows:
- Determine the client's total monthly Personal Needs Allowance (PNA), CSMA, or FMA for a full month.
- Divide the client's monthly PNA, CSMA, or FMA by the actual number of days in the calendar month. This is the client's daily deduction rate which is used for this purpose only.
- Determine the number of days in the calendar month the client expects to reside in the facility and multiply the number of days by the daily deduction then round up.
- The result is the amount of income the client may retain for the PNA, CSMA, or FMA.

24.7.6 Determining the Client's Total Contribution

If the individual is a full Medicaid coverage client or in the Nursing Facility Medicaid coverage group without a spenddown, the resource amount determined in the post eligibility process from above is his total cost contribution. Because the amount of medical expenses used to meet the client's spenddown cannot be paid by Medicaid, the spenddown amount becomes part of the client's contribution toward his cost of care, unless the client has a community spouse. This amount is added to the resource amount determined above to determine the client's total monthly contribution toward the cost of his nursing care.

West Virginia Income Maintenance Manual Chapter 4, Appendix A lists income limits:

300% of the maximum SSI payment: $2,829
Minimum Spousal Maintenance Standard: $2,465
Maximum Spousal Maintenance Standard: $3,853.50
Heating/Cooling Standard Utility Allowance: $496

DISCUSSION

Pursuant to agency policy and federal regulations, client's contribution toward the cost of nursing facility care is determined by applying the allowable income deductions to the gross countable income. The remainder, after all allowable deductions, is the resource amount, which is the amount the client must contribute toward his cost of care.

[redacted] contested the amount of the Appellant's monthly contribution and the Respondent's calculation of her monthly earned income.

Policy stipulates that to determine a monthly amount, an average of all the income received within 30 days of the date of application is used and can be reasonably expected to continue throughout the certification period. Once an average of the income is determined, conversion of the income to a monthly amount is used by multiplying the income based on the frequency of pay. The multiplier for individuals paid every two weeks is 2.15.

The Respondent testified that [redacted] two paystubs received in April 2024 were averaged together, then multiplied by 2.15 to arrive at the $4,072.54 monthly amount used in determining the Appellant's monthly contribution. The Respondent stated that the Appellant submitted four paystubs for consideration, and all four paystubs included overtime pay. Although [redacted] contended that she does not usually receive overtime, the year-to-date amounts from the paystubs provided indicated that [redacted] had been receiving consistent overtime hours. The Respondent acted in accordance with policy in determining [redacted] monthly earned income using the steps found in policy and using overtime pay.

The Appellant's gross Social Security income of $1,846.60 is less than 300% of the maximum SSI payment amount of $2,829, therefore he meets the gross income test to receive Long Term Care Medicaid without a spenddown.

To determine if the Appellant is entitled to the community spouse maintenance allowance, the following steps found in policy are used:

> Step 1: Add the actual shelter cost and the amount of the current SNAP Heating/Cooling Standard (HCS). **$496 Heating/Cooling Standard**
>
> Step 2: Compare the total of the costs in Step 1 to 30% of the minimum SMS ($739.50). When the shelter/utility costs exceed 30% of the minimum SMS, subtract the 30% amount from the shelter/utility costs. **$496 minus $739.50 equals $0**

Step 3: Add the remainder from Step 2 to the minimum SMS. This amount, not to exceed the maximum SMS, is used in Step 5. **$0 plus $2,465 equals $2,465**

Step 4: Add together the community spouse's gross, countable earned and unearned income. **$4,072.54 gross earned income**

Step 5: Subtract the Step 4 amount from the amount determined in Step 3 and if there are any cents, round the resulting amount up. This is the amount subtracted from the income of the institutionalized spouse for the needs of his community spouse. If the Step 4 amount is equal to or greater than the Step 3 amount, no deduction is allowed. **$2,465 minus $4,072.54 equals $0**

The Appellant was not entitled to receive the community spouse maintenance allowance deduction. To determine the Appellant's monthly contribution towards his cost of care, the following steps in policy are used:

	$1,846.60	Gross Social Security income
-	$50	Personal Needs Allowance
=	$1,796.60	Remainder
-	$0	Community Spouse Maintenance Allowance
=	$1,796.60	Remainder
-	$0	Family Maintenance Allowance
=	$1,796.60	Remainder
-	$0	Outside Living Expenses
=	$1,796.60	Remainder
-	$209.60	Medicare Premium
=	$1,587	Total Contribution

The Respondent calculated the Appellant's monthly contribution, effective May 2024, as $1,587. To determine the Appellant's monthly contribution for April 2024, the amount is prorated over the actual number of days the Appellant was institutionalized:

	$1,587	Monthly Contribution
÷	30	Number of Days in April
=	$52.90	Daily Contribution Rate
x	20	Number of Days Resided in Nursing Facility in April
=	$1,058	Total Contribution for April

The prorated amount for the Appellant's monthly contribution for April 2024 was $1,058.

In determining if the Appellant was eligible to receive a deduction for the community spouse maintenance allowance, the Respondent applied the heating/cooling standard utility allowance of $496 in Step 1 of the calculations. However, there was no testimony or documentation presented to indicate that the Appellant and [redacted] do not have any shelter expenses. The Application for Long Term Care Medicaid (Form DFA-MA-1) does not inquire if there are shelter/utility expenses and there is no evidence that [redacted] was questioned if any shelter expenses existed.

Whereas a full determination of the Appellant's entitlement to the community spouse maintenance allowance cannot be made without consideration of the Appellant's shelter expenses, if any, the Appellant must be given the opportunity to provide verification of any shelter expenses to determine if an additional income deduction for the community spouse maintenance allowance can be applied.

[redacted] verified that the Appellant pays $115.80 for a health insurance premium that is deducted from his monthly Social Security benefits. This deduction was not applied to the Appellant's monthly contribution until September 2024. The Appellant is entitled to receive a non-reimbursable medical expense deduction for his health insurance premium paid in April, May, June, July and August 2024 for which he was not previously given credit.

CONCLUSIONS OF LAW

1) A client's contribution toward the cost of nursing facility care is determined by applying the allowable income deductions. The remainder, after all allowable deductions, is the resource amount, which is the amount the client must contribute toward his cost of care.

2) The Respondent applied the personal needs allowance deduction and a non-reimbursable medical expense deduction for the Medicare premium when determining the Appellant's monthly contribution.

3) To determine if the client is eligible for the community spouse maintenance allowance deduction, the total shelter and utility costs are compared to thirty percent of the minimum spousal maintenance standard.

4) There was no documentation provided that [redacted] was afforded the opportunity to report and verify shelter expenses at application or during an interview.

5) The Appellant's entitlement to the community spouse maintenance allowance cannot be fully determined without consideration of shelter expenses.

6) The Appellant had a health insurance premium deducted from his monthly Social Security benefits for April, May, June, July and August 2024 for which he was not given a deduction.

7) The Appellant is entitled to receive a deduction for the months he paid the health insurance premium for which he was not previously given credit.

DECISION

It is the decision of the State Hearing Officer to **reverse** the decision of the Respondent in the calculation of the Appellant's monthly contribution towards his cost of care at the nursing facility. The matter is hereby **remanded** to the Respondent for consideration of any shelter expenses and recalculation of the community spouse maintenance allowance and a non-reimbursable medical expense deduction for the payment of April, May, June, July, and August 2024 health insurance premium.

ENTERED this 25th day of September 2024.

_____

Kristi Logan
Certified State Hearing Officer