May 29, 2024

[redacted]

RE: [redacted] v. WV DoHS/ BFA
ACTION NO.: 24-BOR-1982

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 ensure 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,

Tara B. Thompson, MLS
State Hearing Officer
Member, State Board of Review

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

cc: Susan Snider, [redacted] DoHS

WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 24-BOR-1982**

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 May 7, 2024.

The matter before the Hearing Officer arises from the Respondent's April 5, 2024 decision to terminate the Appellant's Medicaid Long-Term Care (LTC) benefits.

At the hearing, the Respondent appeared by Susan Snider, Monongalia County DoHS. The Appellant was represented by her son, [redacted] Appearing as a witness on behalf of the Appellant was [redacted] her son. All witnesses were placed under oath and the following exhibits were entered into the record.

Department's Exhibits:
D-1 Notice, dated April 5, 2024
D-2 Medicaid Review Form, due March 31, 2024
D-3 Case Comments, dated November 20, 2020 through
D-4 Asset Verification System (AVS) information
D-5 [redacted] Consolidated Statements
D-6 West Virginia Income Maintenance Manual excerpts

Exhibits:
A-1 Appellant bank statement calculation chart
[redacted] Consolidated Statements

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 is a resident of [redacted]

2) The Respondent's record reflects that [redacted] has been the Appellant's authorized representative since at least 2022 (Exhibit D-3).

3) The Appellant received Medicaid LTC benefits (Exhibit D-3).

4) For 2024, the monthly maximum SSI amount is $943 for an individual.

5) From July 2023 through February 2024, the Appellant paid $328.75 for monthly United Healthcare premium costs (Exhibits A-1 and D-3).

6) On April 5, 2024, the Respondent issued a notice to the Appellant at [redacted] advising the Appellant that her Medicaid LTC benefits would be terminated after April 30, 2024, because her income and assets exceeded the eligibility limits. The notice also advised she was required to contribute more money to her cost of care because her income increased (Exhibit D-1).

7) The April 5, 2024 notice was issued to the Appellant at the Facility, not to the Appellant's authorized representative (Exhibit D-1).

8) On February 12, 2024, a Medicaid review form was issued to the Appellant at the Facility, not to the Appellant's authorized representative (Exhibit D-2).

9) On the February 2024 Medicaid review form, *Appendix C*, the pre-populated information revealed [redacted] was the Appellant's authorized representative (Exhibit D-2).

Assets

10) On May 7, 2024, before the hearing, the Respondent corrected an asset calculation error and retroactively reinstated the Appellant's Medicaid LTC benefit eligibility to May 1, 2024.

11) The Respondent did not issue a notice before the hearing to the Appellant's representative advising him of her benefit reinstatement.

12) Statements from [redacted] Bank checking accounts nos.: [redacted] verified the balance amount on the first day of each month, from March 2019 through March 2024 (Exhibit D-4). The Appellant was one of multiple joint account holders for each account (Exhibits D-4 and D-5).

13) Statements from [redacted] Bank savings account no.: [redacted] verified the balance amount on the first day of each month from March 2019 through March 2024 (Exhibit D-4). The Appellant was one of multiple joint account holders (Exhibits D-4 and D-5).

Income

14) The April 5, 2024 notice reflected $4,727.11 monthly gross unearned income for the Appellant (Exhibit D-1).

15) The Respondent deducted $50 for *Personal Allowance* from the Appellant's income (Exhibit D-1).

16) The Respondent deducted $174.70 for Medicare premium costs and $328.75 for other health insurance premiums from the Appellant's monthly gross unearned income (Exhibit D-1).

17) The Spenddown amount reflected on the notice was $4,507.11 (Exhibit D-1).

18) On February 25, 2024, the Respondent received the Appellant's Medicaid eligibility review form, signed by [redacted] (Exhibits D-2 and D-3).

19) The February 25, 2024 review form reflected pre-populated income amounts for the Appellant — $2,111.90 monthly Social Security income and $2,372.84 monthly pension/retirement income (Exhibit D-2).

20) The total combined unearned income reflected on the February 12, 2024 review form was $4,484.74 (Exhibit D-2).

21) [redacted] applied a handwritten signature acknowledging understanding that "if my income is above the Medicaid limits, I may be eligible to receive a medical card if I have excess medical bills. I further understand that my Worker will advise me of the amount of medical bills I have to show and that I have 30 days from the date I apply to provide the bills. The bills can be paid or unpaid…" and "My Worker will explain which bills cannot be used and why" (Exhibit D-2).

22) On March 20, 2024, the Respondent noted "Checked SOLQ & DX" and recorded that the Appellant's gross monthly unearned income was $2,178.70 Retirement, Survivors, and Disability Insurance (RSDI) and $2,548.41 pension (Exhibit D-3).

23) On March 20, 2024, the Respondent considered $174.70 for the Appellant's Medicare Parts A and B premium and $328.75 for the Appellant's health insurance premium (Exhibit D-3).

24) The evidence revealed that from July 31, 2023, through March 29, 2024, the Appellant consistently had $2,548.41 of pension income deposited into Checking Account No.: [redacted] (Exhibit A-1).

25) The evidence revealed that from July 19, 2023, through December 20, 2023, the Appellant consistently had her $1,947 RSDI income deposited into Savings Account No. [redacted] (Exhibit A-1).

26) The evidence revealed that from January 17, 2024, through March 20, 2024, the Appellant consistently had her $2,004.00 RSDI income deposited into Savings Account No. [redacted], and then transferred assets to Checking Account Nos.: [redacted] (Exhibit A-1).

Patient Contribution Amount

27) The April 5, 2024 notice provided the Appellant must pay $4,507.11 for her Total Contribution toward her facility costs (Exhibit D-1).

28) On February 13, 2023, the Appellant's cost of care was $9,214.80; and Monthly Spenddown was $4,264.74 (Exhibit D-3).

APPLICABLE POLICY

WVIMM § 24.4.2 *Redetermination Process* provides in relevant sections: Redeterminations are completed annually and no interview is required. The eligibility system alerts the Worker when a redetermination is due and automatically sends a redetermination form to the client. The redetermination may be completed by the client or his authorized representative.

WVIMM § 24.4.1.C.5 *Who Must Sign* provides in relevant sections: The application or redetermination form must be signed by the applicant or the authorized representative.

WVIMM § 24.6.2 *The Income Group* and § 24.7 *Income for Eligibility Determinations* provide in relevant sections: Only the countable income of the institutionalized individual is used to determine her eligibility. Once Medicaid eligibility is established, the client's contribution toward her cost of care in the facility is determined in the post-eligibility process described in Section 24.7.3.

WVIMM § 24.7.1 *Budgeting Method* provides in relevant sections: See Section 4.6 for generally applicable information about determining income. Monthly income is determined based on averaging income over multiple months, if applicable, and converting or prorating income for periods other than monthly from each source. For each month of residence in a facility, all countable income must be used in determining eligibility and in post-eligibility calculations.

WVIMM § 4.6.1 *Budgeting Method* provides in relevant sections: Eligibility is determined monthly. Therefore, it is necessary to establish 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.

WVIMM § 4.6.1.B *Consideration of Past Income* provides in relevant sections: First, the Worker must determine the amount of income received by the Income Group (IG) in the 30 calendar days before the redetermination date. The income from this 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, the Worker considers income for the period he determines to be reasonable. All pay periods during the appropriate period must be considered and must be consecutive.

WVIMM § 4.6.1.D *How to Use Past and Future Income* provides in relevant sections: The monthly income amount is determined based on the frequency of receipt and whether the amount is stable or fluctuates. For benefits received monthly, use the actual monthly amount when the amount is stable.

WVIMM § 6.3.4.B *Worker Requested Verification – State On-Line Query (SOLQ)* provides in relevant sections: SOLQ provides direct access to the Social Security Administration (SSA) databases.

WVIMM § 6.3.4.A.1 *State Data Exchange (SDX)* provides in relevant sections: State Data Exchange (SDX) information is considered verified upon receipt for all programs and is not subject to independent verification.

WVIMM § 24.19.1 *Eligibility* provides in relevant sections: The individual must have gross countable income at or below 300% of the SSI payment level. When income exceeds this limit, the client may be determined eligible for a monthly spenddown to the Medically Needy Income Level (MNIL) and become eligible. See Section 24.7.2.D.

WVIMM § 24.7.2.D *SSI-Related/Monthly Spenddown* provides in relevant sections: The MNIL for one person is always used. See Chapter 4, Appendix A. If a client is not otherwise eligible by having QMB, full coverage Medicaid, or Nursing Facility coverage group, his eligibility as an SSI-Related Medicaid client with a monthly spenddown must be explored.

WVIMM § 23.11.5.A *Nursing Facility* provides in relevant sections: To be eligible, the client's income cannot exceed 300% SSI Payment Level.

WVIMM § 23.11.5.B *SSI-Related/Monthly Spenddown Group* provides in relevant sections: To determine eligibility, the MNIL for one person must be considered.

WVIMM Chapter 4, Appendix A provides in relevant sections: For a one-person AG, the MNIL is $200.

WVIMM § 24.7.2.D.1 *Spenddown Calculation* provides in relevant sections: When the monthly Medicaid rate for the facility in which the client resides equals or exceeds his monthly spenddown amount, the spenddown is assumed to be met and Medicaid eligibility is established.

If the monthly spenddown amount exceeds the monthly Medicaid rate for the facility, the client may become eligible for Medicaid based on a six-month period of consideration (POC), but not

for payment of nursing facility services. The Medicaid daily rate for the facility is multiplied by 30 to determine the average monthly rate. The daily rates are found only on the Division of Family Assistance (DFA) intranet page. The rates are updated at least semi-annually. Any requests for the rates must be made under the Freedom of Information Act (FOIA) to the DoHS Office of the Deputy Secretary, Division of Accountability and Management Reporting. See Section 24.7.7.7 for examples:

Nursing Home Medicaid Rate Desk Guide (October 2023) provides in relevant part: As of October 2023, the daily rate for [redacted] is $327.37.

WVIMM § 24.19. *Post-Eligibility* provided in relevant sections: When the client has income at or below 300% of the SSI payment level or is eligible for a spenddown to the MNIL level, the post-eligibility process determines the client's contribution for her cost of care. See Section 24.7.

WVIMM § 24.7.3 *Post-Eligibility Process* provides in relevant sections: In determining the client's contribution toward his cost of nursing facility care, the Worker must apply only the income deductions allowed. 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 her nursing care, except when there is a community spouse.

WVIMM § 24.7.3.A *Income Disregards and Deductions* through § 24.7.3.A.5 provide in relevant parts: Only the items listed may be deducted from the client's gross income in the post-eligibility process:

- Client's Personal Needs Allowance (PNA). For most residents, the monthly amount deducted is $50.
- Community Spouse Maintenance Allowance (CSMA)
- Family Maintenance Allowance (FMA) – when the institutionalized individual has family members living with the community spouse and who are financially dependent on them.
- Outside Living Expenses (OLE)- for maintenance of a home when a physician has certified in writing that the individual is likely to return to the home within six months.
- Non-Reimbursable Medical Expenses (NRME): 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, for which the client will not be reimbursed, are subtracted from his remaining income.
    - Deductible Premiums: include any portion of the Medicare Part D premium that is not covered by the Low Income Subsidy. The total deduction for medical insurance premiums is given to the person who pays the premium.
    - For all AGs, the amount of the client's spenddown, if any, is treated as a non-reimbursable medical expense and subtracted from the client's income along with any other medical expenses the client may have.

Expenses that cannot be used as a deduction for non-reimbursable medical expenses include bills for non-payment of the client contribution after Medicaid eligibility for nursing facility services is approved.

Code of Federal Regulations Title 42 § 435.725 explains: The post-eligibility treatment of income for institutionalized individuals is as follows:

> ***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.

DISCUSSION

The Respondent terminated the Appellant's Medicaid LTC benefits after April 30, 2024, because her income and assets exceeded the eligibility limit. The April 5, 2024 notice advised the Appellant was required to contribute more money to her cost of care because her income had increased. The Appellant's representative contested the Respondent's calculations.

The Board of Review must determine, based on a preponderance of submitted evidence, whether the Respondent correctly calculated the Appellant's income and contribution for cost of care amounts. The Hearing Officer may not grant deductions or eligibility exceptions beyond what is permitted in the policy.

Assets

On April 5, 2024, the Respondent notified the Appellant her Medicaid LTC benefits would be terminated after April 30, 2024 because the Appellant's assets exceeded the eligibility limit.

During the hearing, the Respondent's representative testified that she made an error calculating the Appellant's assets and reinstated the Appellant's benefits, effective the day of the hearing. The Respondent's representative affirmed that she incorrectly based the Appellant's termination on her asset calculation. The Respondent's representative testified that the Appellant's benefits were retroactively reinstated to May 1, 2024. The Respondent's representative testified that a notice would be issued to the Appellant within 24 hours advising of her benefit reinstatement. The issue of Medicaid LTC termination based on excessive assets is moot.

Income

To be eligible for Medicaid LTC, the Appellant's gross countable income had to be equal to or below 300% of the SSI payment level. The policy requires the Respondent to consider, at minimum, the gross income received by the Appellant in the 30 days before the date of redetermination. The Respondent received the Appellant's review form on February 25, 2024. Thirty days before the February 25, 2024 review form was December 26, 2023. The regulations state that income considered cannot exceed six months. Because the Appellant provided reliable bank statements for a longer period, the Hearing Officer considered the Appellant's income from August 2023 through February 2024.

The Respondent's case comments reveal the Appellant considered $2,178.70 monthly RSDI and $2,548.41 monthly pension for the Appellant, which was consistent with the $4,727.11 monthly gross unearned income reflected on the Respondent's April 5, 2024 notice.

The preponderance of evidence revealed that periodic increases in the Appellant's RSDI amount occur but remain stable each month until the next increase. According to the submitted evidence, the Appellant's RSDI monthly deposit increased to $2,004 in January 2024.

The policy requires the total countable gross income to be considered when determining Medicaid LTC eligibility. While the submitted bank statements reveal monthly deposit amounts, the statements do not clarify whether the deposit amount reflected gross or net income. During the hearing, the Appellant's representative testified that the Appellant's $174.70 Medicare premiums were deducted from the Appellant's RSDI benefit before being deposited into her account. While the submitted information did not specify the RSDI gross and net income amounts, the Respondent's March 20, 2024 case comments indicate the Appellant's $2,178.70 RSDI income was verified by SOLQ.

$ 2,178.70	gross RSDI income
- 174.70	Medicare premium
$ 2,004.00	net RSDI income

After deducting the amount of the Appellant's Medicare premiums, the remaining $2,004.00 was consistent with the amount of monthly RSDI income deposited into the Appellant's account. The preponderance of evidence revealed that the Appellant could reasonably expect to receive $2,178.70 gross monthly RSDI income.

At the time of the Respondent's April 5, 2024 decision, the evidence revealed that the Appellant had $2,548.41 in pension deposited monthly into her savings account. The submitted evidence did not indicate any deductions taken from the amount before the monthly deposit. The preponderance of evidence revealed that the Appellant could reasonably expect to receive $2,548.41 gross monthly pension income.

$ 2,178.70	gross monthly RSDI income
+ 2,548.41	gross monthly pension
$ 4,727.11	gross monthly income

The evidence revealed that the Appellant's gross monthly unearned income was $4,727.11. The policy requires that the Appellant's eligibility be established as SSI Related/Monthly Spenddown and calculated as follows:

$ 4,727.11	gross monthly unearned income
- 20.00	SSI Income Disregard
$ 4, 707.11	Remainder
- 200.00	MNIL for one person
$ 4, 507.11	Monthly Spenddown

The policy provides that the Medicaid daily rate for the facility is multiplied by 30 to determine the average monthly rate.

$ 327.37 [redacted] Daily Rate x 30 = $ 9,821.10 monthly facility rate

Because the Facility's monthly Medicaid rate exceeds the Appellant's $4,507.11 monthly spenddown, the spenddown is assumed to be met and Medicaid eligibility is established.

Resource Payment Amount

The policy provides that when the client has income at or below 300% of the SSI payment level or is eligible for a spenddown to the MNIL level, the post-eligibility process is used to determine the client's contribution to her cost of care. On April 5, 2024, the Respondent determined that $4,507.11 was the amount of her monthly contribution for the cost of her long-term care. The Appellant's representative testified that paying the Appellant's $328.75 insurance premium and the $4,507 total cost of nursing home care exceeded the Appellant's $4,552.41 monthly income for 17 months. The Appellant's representative testified that the Appellant does not have the financial resources available to retain the $50 personal allowance. The Appellant's representative inquired about whether she could be reimbursed for overpayment of her total cost of nursing home care.

During the hearing, the Appellant's representative inquired whether any other deductions could be applied to the Appellant's income. The policy and federal regulations list permitted income deductions in the post-eligibility process. The submitted information did not indicate that further allowable income deductions could be applied.

The evidence revealed that the Appellant's gross monthly unearned income was $4,727.11, not the $4,552.41 monthly net income amount considered by the Appellant's representative. The policy requires that the Appellant's eligibility be established as SSI Related/Monthly Spenddown and calculated as follows:

$ 4,727.11	gross monthly unearned income
- 20.00	SSI income disregard
$ 4, 707.11	remainder
- 200.00	MNIL for one person
$ 4, 507.11	monthly spenddown

The policy provides that the Medicaid daily rate for the facility is multiplied by 30 to determine the average monthly rate.

$ 327.37 [redacted] Daily Rate x 30 = $ 9,821.10 monthly facility rate

Because the Facility's $9,821.10 monthly Medicaid rate exceeds the Appellant's $4,507.11 monthly spenddown, the spenddown is assumed to be met and Medicaid eligibility is established. The preponderance of evidence revealed that the Respondent incorrectly terminated the Appellant's Medicaid LTC benefits.

The policy and regulations provide that post-eligibility calculations are performed as follows:

$ 4,727.11	gross monthly unearned income
- 50.00	personal needs allowance

$ 4,677.11	remainder
- 174.70	Medicare premium costs
$ 4, 502.41	remainder
- 328.75	United Healthcare premium costs
$ 4, 173.66	remainder
- 4, 507.11	Spenddown (non-reimbursable medical expenses)
$0	resource amount

The Appellant has no resource amount, so her total contribution is $4,507.11, her spenddown amount.

Whereas the Respondent applied all income deductions allowed by policy and federal regulations, the Respondent's decision to increase the Appellant's monthly contribution amount is affirmed. Because the preponderance of evidence revealed that the Respondent's calculations aligned with the policy instruction, the Appellant's request for the Appellant's cost of care reimbursement could not be granted.

CONCLUSIONS OF LAW

1) The Respondent may terminate a recipient's Medicaid LTC eligibility when the household's assets or income exceed the eligibility limit.

2) The Respondent stipulated that an error occurred calculating the Appellant's assets and reinstated her Medicaid LTC benefits before the hearing without issuing a notice to the Appellant's representative.

3) To be eligible for Medicaid LTC, the Appellant's gross countable income had to be at or below $2,829 — 300% of the Supplemental Security Income (SSI) payment level.

4) The Appellant's $4,727.11 gross countable income exceeded 300% of the SSI maximum payment level.

5) When the Facility's monthly Medicaid rate exceeds the Appellant's monthly spenddown amount, the spenddown is assumed to be met and Medicaid LTC eligibility is established.

6) The preponderance of evidence revealed that the Facility's $9,821.10 monthly rate exceeded the Appellant's $4,507.11 monthly spenddown.

7) Only the income deductions permitted by policy may be applied when determining the Appellant's monthly contribution owed to the nursing facility.

8) The preponderance of evidence demonstrated that the Appellant's monthly spenddown amount was correctly calculated.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Respondent's decision to terminate the Appellant's Medicaid Long-Term Care benefits after April 30, 2024. The Respondent's calculations of the Appellant's total cost of nursing home care are **UPHELD**.

ENTERED this 29th day of May 2024.

_____

Tara B. Thompson, MLS
State Hearing Officer