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

[redacted] **2014**
Signature Confirmation

Client ID # [redacted]
Request # 624657

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2014, the Department of Social Services (the "Department") sent [redacted] a Notice of Action ("NOA") denying benefits to [redacted] (the "Applicant") under the Medicaid for Long Term Care program.

On [redacted] 2014, [redacted], the Applicant's daughter and Power of Attorney ("POA"), (the "Appellant"), requested an administrative hearing to contest the Department's decision to deny such benefits.

On [redacted] 2014, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2014.

On [redacted] 2014, counsel for the Appellant requested a continuance of the hearing due to an emergency.

On [redacted] 2014, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice rescheduling the administrative hearing for [redacted] 2014.

On [redacted] 2014, in accordance with sections 17b-60, 17-61 and 4-176e to 4-189 inclusive, of the Connecticut General Statutes, OLCRAH held an administrative hearing. The following individuals were present at the hearing:

[redacted] the Appellant, daughter and power of attorney ("POA") for her mother, the Applicant, [redacted]
[redacted] counsel representing the Appellant and her mother
Susan Debevec, representing the Salmon Brook care facility
Christine Moffitt, Department's representative
Maureen Foley-Roy, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department's decision to deny the Applicant's application for medical assistance for failing to provide information was correct.

FINDINGS OF FACT

1. On [redacted] 2013, the Department received an application for Medicaid for long term care completed by the Applicant's POA and submitted by her attorney, [redacted] (the "Attorney"). (Exhibit A: Long Term Care/Waiver Application)

2. On [redacted] 2014, the Attorney sent a letter and statement to the Department claiming that transfers of the Applicant's funds made to the POA were in exchange for care that the POA and her husband had provided for the Applicant for the previous six years. (Exhibit E: Schedule A)

3. On [redacted] 2014, in response to Schedule A; the Department's medical director's office requested a written statement from the POA with specific details regarding the care provided by the POA to the Applicant and a detailed statement from the Applicant's physician as to her functional status and nature of services provided. (Exhibit F: Memo from Office of Medical Director)

4. On [redacted] 2014, the Department sent a Verification We Need form with a due date of [redacted], 2014 to the Attorney's office requesting the information required by the Medical Director's office; the written statement from the POA with details describing the care that she had provided and statement from the Applicant's physician regarding her condition at that time. (Exhibit D: Verification We Need Request #1)

5. On [redacted], 2014, in response to an inquiry regarding the information requested on [redacted], 2014, the Applicant's attorney's office sent the Department an email advising that they had been in contact with the POA via both letter and telephone and that the POA was requesting the medical information. The email also said the office would be in touch with the POA that same day for an update. (Exhibit K: emails)

6. On [redacted] 2014, the Applicant's attorney's office sent the POA a letter advising that they had not received any of the information that had been requested in [redacted] and Medicaid benefits could be denied if the information was not provided. (Page 128 of Appellant's exhibit A)

7. On [redacted] 2014, the Department denied the application for Medicaid for Long Term Care because none of the information requested on the [redacted] 2014 Verification We Need list had been received. (Exhibit N: Notice of Denial)

8. On [redacted], 2014, the facility where the Applicant was living submitted another application to the Department. (Exhibit B: Application received [redacted] 2014)

9. On [redacted] 2014, the Department's office of the Medical Director determined that any transfers made from the Applicant to the POA were for other valuable consideration and not to qualify for Medicaid. (Exhibit H: Letter from Medical & Clinical Consultant Team)

10. On [redacted] 2014, the Department granted Medicaid for Long Term Care for the Applicant effective [redacted] 2014. (Exhibit O: Notice of [redacted] 2014)

CONCLUSIONS OF LAW

1. Section 17b-2 of the Connecticut General Statutes authorizes the Commissioner of the Department of Social Services to administer the Medicaid program.

2. Uniform Policy Manual ("UPM") § 1010.05 (A) (1) provides that the assistance unit must supply the Department in an accurate and timely manner as defined by the Department, all pertinent information and verification which the Department requires to determine eligibility and calculate the amount of benefits.

3. UPM § 1015.05 C states that the Department must tell the assistance unit what the unit has to do to establish eligibility when the Department does not have sufficient information to make an eligibility determination.

4. The Department was correct when it issued the W1348-Verification We Need form with a listing of outstanding information needed to determine eligibility.

5. UPM § 1505.35 C1 c(2) provides that a standard of promptness is established as the maximum time period for processing applications. For applicants for Medical Assistance on the basis of age; that standard is forty-five calendar days.

6. UPM § 1505.40 B 5 a (1) and (2) provide that regardless of the standard of promptness, no eligibility determination is made when there is insufficient verification to determine eligibility when the Department has requested verification and at least one item of verification has been submitted by the assistance unit within a time period designated by the Department but more is needed.

7. UPM § 1505.40 B 5 b provides that an additional 10 day extension for submitting verification shall be granted, as long as after each subsequent request for verification at least one item of verification is submitted by the assistance unit within each extension period.

8. UPM § 3029.05 A provides that there is a period established, subject to the conditions described in this chapter, during which institutionalized individuals are not eligible for certain Medicaid services when they or their spouses dispose of assets for less than fair market value on or after the look-back date specified in 3029.05 C. This period is called the penalty period, or period of ineligibility.

9. UPM § 3029.10 G provides that an institutionalized individual or his or her spouse may transfer an asset without penalty if it is demonstrated with clear and convincing evidence that he or she intended to dispose of the asset in return for other valuable consideration. The value of the other valuable consideration must be equal to or greater than the value of the transferred asset in order for the asset to be transferred without penalty.

10. The Department was correct when it determined that the Appellant did not provide clear and convincing evidence that the Applicant made transfers for other valuable consideration.

11. UPM § 1505.40 B.1 (c) (2) provides that if consideration of specific circumstances is contingent upon the applicant providing verification and the applicant fails to provide such verification, then the circumstance is disregarded in the eligibility determination.

12. UPM § 3029.35 A 1 and 2 provides that prior to denial or discontinuance of LTC Medicaid benefits, the Department notifies the individual and his or her spouse of its preliminary decision that a transfer of an asset is determined to have been improper. The notification contains a clear explanation of both the reason for the decision and the right of the individual or his or her spouse to rebut the issue within ten days.

13. The Department failed to make a determination regarding the transferred

assets when it did not receive the request information regarding other valuable consideration.

14. The Department failed to inform the Appellant of a preliminary decision that the Applicant had transferred assets in order to qualify for assistance and failed to give the Appellant an opportunity to rebut these findings.

15. The Department was incorrect when it denied the application for Medicaid for Long Term care without giving the Appellant an opportunity to rebut a transfer of asset determination.

DISCUSSION

On [redacted], 2014, the Department sent a Verification We Need list requesting information that applied solely to the Appellant's claim that transfers of assets had been made for other valuable consideration; specifically that the care that the Appellant provided had prevented her mother from being institutionalized at a much earlier date. When the Appellant did not provide the requested information and did not offer any good cause for failing to do so, the Department should have continued to process that application and make a determination on the transferred assets without information on a claim of other valuable consideration. If that meant that the Department considered those transfers improper, the regulations require that the Department send proper notification of the proposed transfer of asset penalty and give the Appellant an opportunity to rebut. The Department denied the Appellant's application without giving her the opportunity to rebut a transfer of asset penalty.

DECISION

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

ORDER

The Department is to reopen and continue to process the [redacted], 2013 application, provided all of the other eligibility factors have been met.

Maureen Foley-Roy
Maureen Foley-Roy,
Hearing Officer

CC: John Hesterberg, Operations Manager
DSS R.O. #11, Manchester

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.