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

[redacted] 2018
SIGNATURE CONFIRMATION

REQUEST #121622

CLIENT ID [redacted]
CASE ID #[redacted]

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2018, the Department of Social Services (the "Department"), issued a Notice of Action to [redacted] (the "Appellant"). The notice stated that the Appellant was eligible for retroactive medical assistance under the Husky D-Long Term Care ("LTC") Facility Coverage group for Low Income Adults, effective [redacted] 2018.

On [redacted] 2018, the Appellant's Representative [redacted] requested an administrative hearing on behalf of the Appellant to contest the effective date of his eligibility for medical assistance under the Husky D-Long Term Care Facility Coverage group for Low Income Adults as determined by the Department.

On [redacted] 2018, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling a hearing for [redacted] 2018 @ 1:00 PM.

OLCRAH granted the Appellant's Representative two continuances, one on [redacted] 2018, and another on [redacted] 2018.

On [redacted] 2018, in accordance with sections 17b-60, 17b-264 and 4-176e to -189, inclusive, of the Connecticut General Statutes, Title 45 Code of Federal Regulations ("CFR") § 155.505(b) and 155.510 and/or 42 CFR § 457.113, inclusive, OLCRAH held an administrative hearing to address the Appellant's effective date of eligibility for medical assistance under the Husky D-Long Term Care Facility Coverage group for Low Income Adults as determined by the Department.

The following individuals were present at the hearing:

[redacted] Appellant's Representative/Conservator (By Telephone)
[redacted]
Ilirjana Sabani, MSW, Representative for the Department (By Telephone)
Amy Koropatkin, Representative for the Department
Hernold C. Linton, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether the Appellant's effective date of eligibility for medical assistance under the Husky D-Long Term Care Facility Coverage group for Low Income Adults as determined by the Department is correct.

FINDINGS OF FACT

1. The Appellant is [redacted] years of age, and resides in a long term care facility. (Hearing Summary)

2. The Appellant previously received medical assistance under the Husky D program for LTC coverage through [redacted] 2017, as his coverage was discontinued for failure to complete the redetermination process. (Hearing Summary; Dept.'s Exhibit #1: Case Notes)

3. On [redacted] 2018, the Department received a completed Renewal of Eligibility ("W1-ER") from the Appellant's Representative. (Hearing Summary)

4. The Department determined that the Appellant's W1-ER was not received within the 90 day grace period, and therefore, a new application was required. (Hearing Summary)

5. There is no evidence that the Department considered the Appellant's untimely W1-ER as a reapplication or as a request for assistance. (Hearing Summary)

6. There is no evidence that after receiving the Appellant's W1-ER, the Department sent out a supplemental request for the additional information needed to determine the Appellant's eligibility. (Hearing Summary)

7. The W1-ER submitted by the Appellant's Representative provided the Appellant's name, address, and appropriate signature. (Hearing Summary)

8. There is no evidence that the Department sent the Appellant or his Representative a written notice of the Department's decision regarding the W1-ER received on [redacted] 2018. (Hearing Summary)

9. On [redacted] 2018, the Department received a reapplication for Medicaid from the Appellant's Representative. (Hearing Summary)

10. On [redacted] 2018, the Department granted the Appellant retroactive medical assistance under the Husky D program, effective [redacted] 2018, based on the reapplication received [redacted] 2018. (Hearing Summary; Dept.'s Exhibit #1: Case Notes)

11. The Department is diverting the Appellant's monthly applied income to cover Medicaid services received during the period of [redacted] 2017 through [redacted] 2017. (Hearing Summary)

CONCLUSIONS OF LAW

1. Section 17b-260 of the Connecticut General Statute provides that the Commissioner of Social Services is authorized to take advantage of the medical assistance programs provided in Title XIX, entitled "Grants to States for Medical Assistance Programs", contained in the Social Security Amendments of 1965 and may administer the same in accordance with the requirements provided therein, including the waiving, with respect to the amount paid for medical care, of provisions concerning recovery from beneficiaries or their estates, charges and recoveries against legally liable relatives, and liens against property of beneficiaries.

2. State statute provides that all of the provisions of sections 17b-22, 17b-75 to 17b-77, inclusive, 17b-79 to 17b-83, inclusive, 17b-85 to 17b-103,inclusive, and 17b-600 to 17b-604, inclusive, are extended to the medical assistance program except such provisions as are inconsistent with federal law and regulations governing Title XIX of the Social Security Amendments of 1965 and sections 17b-260 to 17b-262, inclusive, 17b- 264 to 17b-285, inclusive, and 17b-357 to 17b-361, inclusive. [Conn. Gen. Stats. § 17b-264]

3. 45 CFR § 155.505(d) provides that an appeals process established under this subpart must comply with § 155.110(a).

4. State statute provides that Husky D or Medicaid Coverage for the Lowest Income Populations program means Medicaid provided to non-pregnant low-income adults who are age 18 to sixty-four, as authorized pursuant to section 17b-8. [Conn. Gen. Stats. § 17b-290(16)

5. The Department correctly determined Husky D/Medicaid as the appropriate medical coverage group for the Appellant.

6. UPM § 1545.25(A) provides that assistance units are required to complete a redetermination form at each redetermination.

7. UPM § 1545.25(B) provides that the redetermination form may be:

   (1) the same form used at the time of application; or

   (2) a form designed specifically for the redetermination process.

8. UPM § 1545.25(C) provides that the Department provides each assistance unit with a redetermination form at the same time unit is issued its notice of redetermination.

9. UPM § 1545.25(D) provides that assistance units that do not complete the redetermination form within the time limits specified in this chapter may be subject to discontinuance or an interruption in benefits.

10. UPM § 1545.25(E) provides that the redetermination form must be signed by someone qualified to complete the redetermination on behalf of the assistance unit.

11. UPM § 1545.45(A) provides that the following provisions apply to AFDC, AABD or MA assistance units whose eligibility was discontinued at the end of the redetermination period because they failed to complete the redetermination process.

    (1) Untimely Filing

        a. Redetermination forms filed in the month following the redetermination month are treated as initial applications if good cause is not established for the untimely filing.

        b. If good cause is established:

            (1) the case is processed as a late redetermination; and

            (2) eligibility is redetermined within five working days of the date the assistance unit completes all required actions.

12. The Department correctly determined that the Appellant did not submit his completed Renewal Form timely.

13. 42 CFR § 435.119 provides for coverage for individual age 19 or older and under age 65 at or below 133 percent of the Federal Poverty Level ("FPL"). It provides in part:

    a. Basis. This section implements section 1902(a)(10)(A)(i)(VIII) of the Act.
    b. Eligibility. Effective [redacted] 2014, the agency must provide Medicaid to individuals who:
        1. Are age 19 or older and under age 65;
        2. Are not pregnant;
        3. Are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act;
        4. Are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part; and
        5. Have household income that is at or below 133 percent FPL for the applicable family size.

14. 42 CFR § 435.906 provides that the agency must afford an individual wishing to do so the opportunity to apply for Medicaid without delay.

15. 42 CFR § 435.907(a) provides that in accordance with section 1413(b)(1)(A) of the Affordable Care Act, the agency must accept an application from the applicant, an adult who is in the applicant's household, as defined in § 435.603(f), or family, as defined in section 36B(d)(1) of the Code, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant, and any documentation required to establish eligibility-

    (1) Via the internet Web site described in § 435.1200(f) of this part;
    (2) By telephone;
    (3) Via mail;
    (4) In person; and
    (5) Through other commonly available electronic means.

    (b) The application must be-

    (1) The single, streamlined application for all insurance affordability programs developed by the Secretary; or

    (2) An alternative single, streamlined application for all insurance affordability programs, which may be no more burdensome on the applicant than the application described in paragraph (b)(1) of this section, approved by the Secretary.

    (c) For individuals applying, or who may be eligible, for assistance on a basis other than the applicable MAGI standard in accordance with § 435.911(c)(2) of this part, the agency may use either-

    (1) An application described in paragraph (b) of this section and supplemental forms to collect additional information needed to determine eligibility on such other basis; or

    (2) An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard. Such application must minimize burden on applicants.

16. 42 CFR § 435.908(a) provides that the agency must provide assistance to any individual seeking help with the application or renewal process in person, over the telephone, and online, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient, consistent with § 435.905(b) of this subpart. (b) The agency must allow individual (s) of the applicant or beneficiary's choice to assist in the application process or during a renewal of eligibility.

17. 42 CFR § 435.911(c)(3) provides that for individuals not eligible on the basis of the applicable modified adjusted gross income standard, the agency must comply with the requirements set forth in § 435.1200(e) of this part. (d) For purposes of paragraph (c)(2) of this section, individuals described in this paragraph include: (1) Individuals whom the agency identifies, on the basis of information contained in an application described in § 435.907(b) of this part, or renewal form described in § 435.916(a)(3) of this part, or on the basis of other

information available to the State, as potentially eligible on a basis other than the applicable MAGI standard; (2) Individuals who submit an alternative application described in § 435.907(c) of this part; and (3) Individuals who otherwise request a determination of eligibility on a basis other than the applicable MAGI standard as described in § 435.603(j) of this part.

18. UPM § 1505.10(A) provides for the filing of an application form as follows:

    (1) That all applicants are required to complete an application form, except as noted below in 1505.10 A.3.

    (2) The Department may utilize a single uniform application for multiple programs, or separate applications for individual programs.

    (3) For all programs except Food Stamps, a new application form is not required if the applicant applies not later than thirty days after being released from a correctional or mental disease facility, was a recipient of cash or medical assistance and lost eligibility, directly or indirectly, because of his or her institutionalization within the twenty-four month period preceding the date of his or her release.

19. UPM § 1505.10(B) provides that for requesting assistance:

    (1) Individuals who desire to obtain aid must file a formal request for assistance.

    (2) The formal request must be made in writing on the application form.

    (3) At a minimum, the following information must be presented:

        a. the full name and address of the applicant; and
        b. the signature of the applicant, caretaker relative or other individual who is requesting assistance on behalf of the applicant.

    (4) The application may be submitted in person or by mail.

    (5) Telephone contacts or other requests for aid which are not written, do not contain the required information, or are not made on the prescribed application form are considered inquiries and do not constitute an application.

    (6) Individuals who appear in person to request assistance must be given an opportunity to file an application for any desired program on the day they personally appear.

20. The Appellant's W1-ER, received on [redacted] 2018 provided the Department with the Appellant's name, address, and appropriate signature, and constitutes a formal request for assistance as provided in the UPM.

21. The regulation provides for the Agency to assist any individual seeking help with the application or renewal process in person, over the telephone, or online, and to send supplemental forms to collect additional information needed to determine eligibility. The Department's dismissal of the Appellant's W1-ER received on

[redacted] 2018 is not in compliance the due process standards set forth in the regulation as the Department failed to send a written notice to the Appellant and his Representative regarding the untimeliness of his W1-ER.

22. UPM § 1560.10 provides that the beginning date of assistance for Medicaid may be one of the following:

    A. the first day of the first, second or third month immediately preceding the month in which the Department receives a signed application when all non-procedural eligibility requirements are met and covered medical services are received at any time during that particular month; or

23. The Department incorrectly determined the month of [redacted] 2018 based on the application received on [redacted] 2018.

DECISION

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

ORDER

1. The Department shall reopen the Appellant's application for medical assistance under the Husky D program as of [redacted] 2018, based on the findings of this hearing decision.

2. The Department will issue a W-1348 to the Appellant and his Representative requesting any additional information needed to determine the Appellant's eligibility, based on the findings of this hearing decision.

3. The Department has thirty (30) days from the date of this hearing decision to provide the undersigned with verification of the Department's compliance with this order.

Hernold C. Linton

Hernold C. Linton
Hearing Officer

Pc: **Patricia Ostroski**, Social Service Operations Manager
DSS, R.O. #52, New Britain

Fair Hearing Liaisons, DSS, R.O. #52, New Britain

[redacted]

Modified Adjusted Gross Income (MAGI) Medicaid and Children's Health Insurance Program (CHIP) Right to Request Reconsideration

For denials or reductions of MAGI Medicaid and CHIP, 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 Legal Counsel, Regulations, and Administrative Hearings, 55 Farmington Avenue, Hartford, CT 06105-3725.

There is no right to request reconsideration for denials or reductions of APTC or CSR.

Right to Appeal

For denials, terminations or reductions of MAGI Medicaid and CHIP eligibility, 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 his 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.