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

[redacted], 2019
SIGNATURE CONFIRMATION

CLIENT ID #: [redacted]
HEARING ID #: 146819

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2019, the Department of Social Services (the "Department") issued a notice of action ("NOA") to [redacted] (the "Appellant") denying her application for Medicaid for the reason "An application was screened in error for your household".

On [redacted], 2019, the Appellant, by her attorney, [redacted]. ("Counsel"), requested an administrative hearing to appeal the denial.

On [redacted] 2019, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted], 2019.

On [redacted] 2019, in accordance with sections 17b-60, 17b-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] Counsel for the Appellant
Patricia Dixon, Department's representative
Ilirjana Sabani, Department employee not participating in hearing

James Hinckley, Hearing Officer

STATEMENT OF THE ISSUE

The issue is whether the Department was correct when it denied the Appellant's [redacted], 2019 Medicaid application because the Department screened the application in error.

FINDINGS OF FACT

1. The Appellant is an 87 year old woman with bibrachial amytrophic diplegia, a form of ALS resulting in total loss of use of upper extremities, and dementia. (Hearing Record)

2. The Appellant resides at home, and requires more care than her son, who is her primary caregiver, is able to provide. (Hearing Record)

3. On [redacted], 2019, The Appellant applied for HUSKY C Medicaid for individuals receiving Home and Community Based Services ("W01"). The application was filed using the Department's long term care application form W-1LTC. (Hearing Record)

4. Applications for Medicaid for payment for nursing home care, or for home and community-based waiver services, are generally assigned to a single worker who processes the application to completion. (Hearing Record, Testimony)

5. On [redacted], 2019, the Appellant sent the Department a second application for Medicaid. The application was filed using the Department's general application form W-1E. (Hearing Record)

6. As of [redacted], 2019, when the Department received the second application form, the Appellant's [redacted], 2019 application for W01 Medicaid was still pending. (Testimony, Hearing Record)

7. Accompanying the [redacted], 2019 application was a letter from Counsel that stated, in part, "We are asking that this W-1E be EXPEDITED pursuant to Provider Bulletin 2017-16 since Ms. [redacted] has an illness that places her at imminent risk of severe harm. We are hoping to obtain HUSKY C for medical insurance coverage so we can obtain home care and services through the Community First Choice program. A W-1 LTC is also pending…but we are asking for HUSKY C to be granted immediately if possible, so we can obtain home care services as soon as possible." (Ex. C: [redacted], 2019 letter from Counsel)

8. The W-1E general application form is used by the Department for multiple programs. The W-1LTC long term care application form is specifically used to

apply for Medicaid for long term care or Medicaid for Home Care Waiver services. (Testimony, Hearing Record)

9. The printed directions on form W-1E state, in part, "To apply for **long term care** (nursing home) or **home based care**, apply online at connect.ct.gov, or in person at a DSS office, or using form W-1LTC…." (emphasis in original) (Ex. E: W-1E form completed on behalf of the Appellant)

10. Also accompanying the [redacted], 2019 application was a copy of a Department Provider Bulletin from May 2017. The Bulletin stated, in part, "Individuals age 65 or older and those receiving Medicare can apply for Medicaid with DSS. The best way for these individuals to receive expedited eligibility processing is to apply online at the Department's web site…and then call the DSS Benefit Center…to request expedited processing due to a medical emergency…." (Ex. D: Provider Bulletin 2017-26)

11. The Appellant reported income on the [redacted], 2019 application that included $1,759.00 per month from Social Security and $904.00 per month from a pension, for total income of $2,663.00. (Ex. E)

12. The Department screened the [redacted], 2019 application as an application for W01 Medicaid. This was a duplication of the [redacted], 2019 W01 Medicaid application that was still pending. (Hearing Record)

13. On [redacted] 2019, the Department asked the Appellant for certain verifications necessary to process her [redacted], 2019 application. The request was sent by a different worker from the one who was processing the Appellant's [redacted], 2019 application. (Ex. 1: W-1348LTC *Verification We Need* form, Hearing Record)

14. On [redacted] 2019, the Department issued a NOA to the Appellant denying her [redacted], 2019 application for the reason, "an application was screened in error for your household." (Ex. B: NOA)

15. After Counsel received the [redacted] 2019 request for information (but before she received the [redacted] 2019 NOA), she emailed the second worker on [redacted] 2019 saying, in part, "I am concerned because you are requesting documents we previously provided to (the first worker)…." (Ex. 4: Email exchange)

16. On [redacted], 2019, the second worker sent an email response to Counsel that read, "First we apologize but client case was duplicated at screening during the screening process and was assigned to both of us. Because (the first worker) has been working on the case from the beginning, everything must go through her and the case I have has been transferred back over to her. Thank-you. T(he first worker) will be working on the case today. Please do all

correspondence through (the first worker), thank-you again." (Ex. E: email exchange)

17. On [redacted] 2019, the Appellant requested a fair hearing. The hearing request stated, "A W-1E was submitted but not processed. It was not screened in error. We request the W-1E be processed." (Hearing Record)

CONCLUSIONS OF LAW

1. The Department is the state agency that administers the Medicaid program pursuant to Title XIX of the Social Security Act. The Department may make such regulations as are necessary to administer the medical assistance program. Conn. Gen. Stat. § 17b-2; Conn. Gen. Stat. § 17b-262

2. The Department's Uniform Policy Manual ("UPM") "is the equivalent of a state regulation and, as such, carries the force of law." *Bucchere v. Rowe*, 43 Conn. Supp. 175, 177 (1994) (citing Conn. Gen. Stat. 17-3f(c) [now 17b-10]; *Richard v. Commissioner of Income Maintenance*, 214 Conn. 601, 573 A. 2d 712(1990)).

3. "The assistance unit has the right to apply for assistance under any of the programs administered by the Department." UPM § 1005.05(A)

4. "The applicant must indicate the programs for which he or she is applying: a. at the time of the application interview; or b. when contacted by the Department for that purpose." UPM § 1505.10(D)(5)

5. "In order to qualify for MA (medical assistance), an individual must meet the conditions of at least one coverage group." UPM § 2540.01(A)

6. The MA coverage croup, "Individuals Receiving Home and Community Based Services (W01)…includes individuals who: 1. would be eligible for MAABD if residing in a long term care facility (LTCF); and 2. qualify to receive home and community-based services under a waiver approved by the Centers for Medicare and Medicaid Services; and 3. would, without such services, require care in an LTCF." UPM § 2540.92(A)

7. "An individual may meet the conditions of two or more coverage groups at the same time." UPM § 2540.01(A)(1)

8. "When the conditions of more than one group are met, assistance is given under the coverage group which is most advantageous to the individual." UPM § 2540.01(A)(2)

9. Based on the information provided to the Department, and the testimony presented at the hearing, "W01" appears to be the appropriate Medicaid coverage group for the Appellant. The Appellant requires extensive care but wants to remain at home and receive home-based services, without which, she would require care in a nursing facility. The W01 coverage group pays for such care.

10. **Although there is no indication that a different Medicaid coverage group would have been more advantageous to the Appellant, if the Appellant wanted to be considered under a different coverage group she needed to contact the worker processing her already-pending application to discuss the possibilities, and the advantages and disadvantages of pursuing eligibility under a different group.**

11. **Different coverage groups are not different programs. There is only one Medicaid program. In order to qualify for Medicaid, an individual must meet the conditions of at least one coverage group. Pursuant to UPM § 2540.01(A)(2), "when the conditions of more than one group are met, assistance is given under the coverage group which is most advantageous to the individual."**

12. "The assistance unit has the right to reapply at *any time after it has been discontinued or has withdrawn its application for assistance*." (emphasis added) UPM § 1005.05(D)

13. **The Appellant had no right to apply on [redacted], 2019 because her [redacted], 2019 application was still pending at the time and had not been denied or withdrawn. If the Appellant wanted her [redacted], 2019 application to determine her eligibility under a different coverage group, because she was potentially eligible under more than one group, she needed to make that known to the worker processing the [redacted], 2019 application. The Department could not accept a new application because two Medicaid applications cannot be pending at the same time.**

14. "The commissioner may implement policies and procedures necessary to…(2) pursue optional initiatives or policies authorized pursuant to the Patient Protection and Affordable Care Act, P.L. 111-148, and the Health Care and Education Reconciliation Act of 2010, including, but not limited, to:…(H) the establishment of a "Community First Choice Option"." Conn. Gen. Stat. § 17b-263c(b)

15. Title 42 of the Code of Federal Regulations ("CFR"), section 441.500 provides as follows:

    (a) Basis. This subpart implements section 1915(k) of the Act, referred to

as the Community First Choice option (hereafter Community First Choice), to provide home and community-based attendant services and supports through a State plan.

(b) Scope. Community First Choice is designed to make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands-on assistance, supervision, or cueing.

16. 42 CFR § 441.510 provides, in relevant part, as follows:

> To receive Community First Choice services and supports under this section, an individual must meet the following requirements:
>
> (a) Be eligible for medical assistance under the State plan;
>
> (b) As determined annually –
>
> (1) Be in an eligibility group under the State plan that includes nursing facility services; or
>
> (2) If in an eligibility group under the State plan that does not include such nursing facility services, have an income that is at or below 150 percent of the Federal poverty level (FPL). In determining whether the 150 percent of the FPL requirement is met, States must apply the same methodologies as would apply under their Medicaid State plan, including the same income disregards in accordance with section 1902(r)(2) of the Act;
>
> …

17. 100 percent of the federal poverty level for a household of one person as of [redacted], 2019 was $1,040.83 monthly, and 150 percent of that figure was $1,561.28. *Federal Register* / *Vol. 84*, *No. 22* / *Friday, February 1, 2019* / *pp. 1167-1168*

18. **Community First Choice is not a program. It is home and community-based services and supports available to certain individuals who are eligible for the Medicaid program.**

19. **In order for Community First Choice to be available to the Appellant, as Counsel indicated she wanted, she needed to qualify for Medicaid under; a) a coverage group such as W01 that pays for (the equivalent of) nursing facility services; or b) if the Appellant's income was less than 150% of the FPL, a coverage group that did not include nursing**

facility services. There is no indication the Appellant could have qualified under any such group in the second category. The Appellant's income is $2,663.00. The income limit for community Medicaid is net income less than the $523.38 medically needy income limit. 150% of the FPL is $1,561.28.

20. Chapter 1500 of the UPM discusses the Eligibility Process. Certain sections of chapter 1500 discuss special treatment applied to certain applications under certain conditions. There is no section of UPM 1500 that provides for expedited processing of Medicaid applications due to medical emergency.

21. UPM § P-1505.35(3) provides guidance on giving priority to emergencies.

22. UPM § 0200 provides, in relevant part, as follows:

> The Uniform Policy Manual (UPM) has two basic components, POLICY and PROCEDURES, which serve distinct purposes and should be used according to their particular function.
>
> POLICY pages have the power of regulation and should be used by DIM staff as a legal basis upon which to make decisions on eligibility issues and related matters in a consistent and uniform manner. Legislators, attorneys, and other interested parties should use the POLICY pages as a reference book which reflects the laws governing the Department's administration of its various programs.
>
> PROCEDURES pages are for the exclusive use of DIM staff….They provide a guide to implementing DIM's policies….PROCEDURES pages have a "P" before their numerical index number…
>
> Where DIM staff should use the POLICY pages to insure statewide uniformity in making decisions, they should exercise flexibility in using the PROCEDURES pages when implementing those decisions. As noted above, PROCEDURES pages are only a guide to implementing policy….A PROCEDURES page should not be used as a basis for an eligibility decision.
> ….

23. UPM § P-1505.35(3) is a procedural page in the UPM. The "P" prefix designates it as such.

24. **No law can be found that provides for "expedited processing" of certain Medicaid applications due to a "medical emergency". However, if such special procedures exist, the Appellant needed to request them from the worker processing the [redacted], 2019 application. Filing a duplicate application was not the correct procedure for the Appellant to request expedited processing of her already pending application. The Department correctly forwarded all of Counsel's communications associated with the [redacted], 2019 application to the worker processing the [redacted], 2019 application.**

25. **The Department was correct when it denied the [redacted], 2019 application due to being "screened in error", and referred the application form and supporting documents to the worker assigned to the Appellant's pending [redacted], 2019 application.**

DISCUSSION

"Coverage Groups" or, in federal Medicaid law, "Eligibility Groups" are ways of qualifying for Medicaid. Individuals can only qualify under one group at a time. Though there are many groups, most often only a single group fits any particular applicant's circumstances. In the unusual circumstance where eligibility is possible under more than one group, the Department will select the most advantageous coverage for the applicant.

When the Appellant filed an application on [redacted], 2019, it was screened as an application for W01 *Medicaid for individuals receiving Home and Community Based Services*, because the Appellant was living at home and seeking coverage for home care services, and because the application was filed using form W-1LTC. W01 eligible individuals are considered "institutionalized", even if not actually residing in an institution, because they would otherwise require institutionalization if not for the receipt of home care services. W01 applications require an examination of 5 years of financial records to determine whether the applicant made any disqualifying transfers of assets during the look-back period.

"HUSKY" refers to publicly-funded medical programs available in Connecticut. It is a designation that is applied not only to Medicaid coverages but also to programs such as the Children's Health Insurance Program (CHIP), which is referred to as "HUSKY B." "HUSKY C" refers specifically to Medicaid Coverage Groups for the elderly or disabled, which are numerous.

When Counsel for the Appellant submitted a new application on [redacted], 2019, it was a *duplicate application*. There was no need for a new application because the Department received an application from the Appellant on [redacted], 2019 that was still pending at the time. The comments in Counsel's letter that accompanied the second application, at least on their face, did not make sense. Counsel tried to

differentiate the new application from the already pending one by saying that the new application was for “HUSKY C”. But the Appellant’s application that was already pending was for W01, *which is HUSKY C*.

Counsel wrote, in part, in her letter accompanying the application, “We are hoping to obtain HUSKY C for medical insurance coverage so we can obtain home care and services through the Community First Choice program”. Counsel also pointedly filed the [redacted], 2019 application using the Department’s “W-1E General Application Form” instead of its “W-1-LTC Long Term Care Application Form.” The primary difference between the forms is that the W-1E form does not ask about assets during the 5-year look-back period.

Community First Choice services are available only as a supplement to Medicaid for individuals who qualify under coverage groups that pay for nursing facility services, which the W-1E form cannot be used to apply for. The services are also available to individuals who have income less than 150% of the FPL and qualify under a different coverage group, but this possibility would not seem to apply to the Appellant since her income far exceeds both 150% of the FPL and the income limit for any other coverage group.

The Appellant could conceivably have reduced her income through contributions to a pooled trust to qualify for community Medicaid. If she did so she would not have qualified for Medicaid Home Care Waiver services but could still have received Community First Choice services. Even if this was Counsel’s unusual plan, it would not have required a new application. She would instead have had to make her intent known to the worker processing the [redacted], 2019 application.

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Counsel stated clearly and on the record that the Appellant was contesting the Department’s denial of her [redacted], 2019 application with this appeal. Counsel is aware of Appellant’s right to appeal the “processing delay” of the [redacted], 2019 application, which was still pending at the time this hearing was held, but deferred any decision on whether to request a separate hearing on that issue.

Despite our understanding at the outset, Counsel made several arguments that are beyond the scope of what this hearing must decide. If the Appellant *is* eligible for some sort of expedited processing, or if she would be better served by some other coverage group, or if the processing of her [redacted], 2019 application has been unnecessarily delayed by the Department, those issues must be taken up with the worker processing the [redacted], 2019 application, or appealed by requesting a separate hearing.

DECISION

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

James Hinckley
Hearing Officer

cc: [redacted].
Patricia Dixon
Peter Bucknall
Jamel Hilliard
hearings.commops@ct.gov

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 06105-3725.

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.