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

[redacted] **2020**
Signature Confirmation

[redacted]
Request # 150099

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted], 2019, the Department of Social Services (the "Department") sent [redacted], (the "Appellant"), a Notice of Action ("NOA") denying her Connecticut Home Care Program for Elders ("CHCPE") Medicaid Waiver application because her assets exceeded the Medicaid asset limit.

On [redacted] 2019, the Appellant, through her attorney Stephen B. Keogh, requested an administrative hearing to contest the denial of CHCPE Medicaid Waiver benefits.

On [redacted] 2019, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a Notice scheduling the administrative hearing for [redacted] 2020.

On [redacted] 2020, the Appellant's attorney requested a continuance, which OLCRAH granted.

On [redacted] 2020, OLCRAH issued a Notice scheduling the administrative hearing for [redacted] 2020.

On [redacted], 2020, 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] Esq., for the Appellant
[redacted] Esq. for the Appellant
[redacted], Appellant's son and POA
Shawn Hardy, Department's Representative via telephone
Megan Finlayson, Department's Representative
Thomas Monahan, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department's decision to deny the Appellant's CHCPE application due to assets in excess of the program limit is correct.

FINDINGS OF FACT

1. On [redacted] 2019, the Appellant applied for Medicaid through the Connecticut Home Care Program for the Elderly. (Appellant's Exhibit 3B: Correspondence with application form)

2. The Appellants is [redacted] years old [D.O.B. [redacted]]. (Appellant's Exhibit 3B: Correspondence with application form)

3. The Appellant's power of attorney ("POA") is her son [redacted] and he is represented by attorneys [redacted] and [redacted]. (Appellant's Exhibit 3B: Correspondence with application form)

4. On the application the Appellant listed income from a promissory note. The note stated that the borrowers were to pay $70,000.00 to the Appellant (the lender) in the form of monthly payments of $465.71 effective [redacted]. The note stated that as of the maturity date of [redacted] any outstanding balance would be paid to the Appellant. (Appellant's Exhibit 3B: Correspondence with application form, Exhibit C: Attorney's fax with promissory note, Exhibit G: attorney's fax with notification of delayed maturity)

5. On [redacted], 2019, the Department received the amortization schedule for the promissory note from the Appellant. The balance owed to the Appellant as of [redacted], 2019 was $60,067.24. (Exhibit C: Attorney's fax including Amortization schedule)

6. On [redacted] 2019, the Department sent the Appellant's POA a Verification We Need form requesting various asset verifications. The form also notified the Appellant that the promissory note's balance of $60,067.24 would be treated as an available asset. (Exhibit F: Verification We Need forms)

7. On [redacted], 2019, the Appellant's attorney informed the Department that they were attempting to sell the promissory note on the secondary market. He requested that the promissory note be counted as an inaccessible asset if they were unable to find a buyer. (Exhibit C: Attorney's fax and letter)

8. On [redacted] 2019, the Department received verification from the attorney of three offers to purchase the promissory note. The highest offer was $41,725.00. The Appellant's attorney accepted the highest offer and requested that the promissory note be treated as a non-countable asset because of the Appellant's good faith to sell the note. (Exhibit D: offer letters and acceptance of offer)

9. On [redacted] 2019, the Department requested the following information regarding the promissory note: A list of payments made on the note, the current balance owed on the note, principal plus interest, and were there any attempts by the Appellant to call in the note after the [redacted] 2019 maturity date. (Exhibit F: Verification We Need form, [redacted]/19)

10. On [redacted], 2019, the Appellant's attorney notified the Department of the payments made by the borrower to the Appellant, the current balance on the note of $59,719.23 and that the parties later postponed the maturity date and agreed to allow the borrower to continue to make monthly payments. (Exhibit G: Attorney's letter, payment history and amortization schedule, [redacted]/19)

11. On [redacted], 2019, the Department denied the Appellant's application for CHCPE Medicaid Waiver because the appellant's assets exceeded the $1,600.00 asset limit. The promissory note valued at $59,719.23 was counted as an available asset by the Department. (Exhibit G: Notice of Action, [redacted]/19)

12. The Appellant reapplied for assistance on [redacted], 2019, and the application remained pending at the time of the hearing. (Testimony)

13. On [redacted] 2019, the Department emailed the Appellant's attorneys and notified them that the offer for the promissory note was acceptable. The email also stated that the Department's position was that the Appellant remained over assets until the note was sold and assets reduced to within the $1,600.00 limit. (Appellant's Exhibit 3B: Correspondence, email [redacted]/19)

14. The issuance of this decision is timely under Connecticut General Statute Section 17b-61(a), which requires that a decision be issued within 90 days of the request for an administrative hearing. The Appellant requested an administrative hearing on [redacted] 2019, and the decision was due on [redacted] 2020. The Appellant requested a continuance of the hearing resulting in a delay of 20 days. Therefore, this decision was due not later than [redacted] 2020 and is therefore timely.

CONCLUSIONS OF LAW

1. Section 17b-2 of the Connecticut General Statutes, authorizes the Department of Social Services to administer the Medicaid program pursuant to Title XIX of the Social Security Act.

2. Connecticut General Statutes § 17b-342 provides for the Connecticut home-care program for the elderly. (a) The Commissioner of Social Services shall administer the Connecticut home-care program for the elderly state-wide in order to prevent the institutionalization of elderly persons (1) who are recipients of medical assistance, (2) who are eligible for such assistance, (3) who would be eligible for medical assistance if residing in a nursing facility, or (4) who meet the criteria for the state funded portion of the program under subsection (i) of this section. For purposes of this section, a long-term care facility is a facility which has been federally certified as a skilled nursing facility or intermediate care facility. The commissioner shall make any revisions in the state Medicaid plan required by Title XIX of the Social Security Act prior to implementing the program. The annualized cost of the community-based services provided to such persons under the program shall not exceed sixty per cent of the weighted average cost of care in skilled nursing facilities and intermediate care facilities. The program shall be structured so that the net cost to the state for long-term facility care in combination with the community-based services under the program shall not exceed the net cost the state would have incurred without the program. The commissioner shall investigate the possibility of receiving federal funds for the program and shall apply for any necessary federal waivers. A recipient of services under the program, and the estate and legally liable relatives of the recipient, shall be responsible for reimbursement to the state for such services to the same extent required of a recipient of assistance under the state supplement program, medical assistance program, temporary family assistance program or supplemental nutrition assistance program. Only a United States citizen or a noncitizen who meets the citizenship requirements for eligibility under the Medicaid program shall be eligible for home-care services under this section, except a qualified alien, as defined in Section 431 of Public Law 104-193, admitted into the United States on or after August 22, 1996, or other lawfully residing immigrant alien determined eligible for services under this section prior to July 1, 1997, shall remain eligible for such services. Qualified aliens or other lawfully residing immigrant aliens not determined eligible prior to July 1, 1997, shall be eligible for services under this section subsequent to six months from establishing residency. Notwithstanding the provisions of this subsection, any qualified alien or other lawfully residing immigrant alien or alien who formerly held the status of permanently residing under color of law who is a victim of domestic violence or who has mental retardation shall be eligible for assistance pursuant to this section. Qualified aliens, as defined in Section 431 of Public Law 104-193, or other lawfully residing immigrant aliens or aliens who formerly held the status of permanently residing under color of law shall be eligible for services under this section provided other conditions of eligibility are met.

3. Connecticut General Statutes § 17b-342 (c) provides the community-based services covered under the program shall include, but not be limited to, the following services to the extent that they are not available under the state Medicaid plan, occupational therapy, homemaker services, companion services, meals on wheels, adult day care, transportation, mental health counseling, care management, elderly foster care, minor home modifications and assisted living services provided in state funded congregate housing and in other assisted living pilot or demonstration projects established under state law. Personal care assistance services shall be covered under the program to the extent that (1) such services are not available under the Medicaid state plan and are more cost effective on an individual client basis than existing services covered under such plan, and (2) the provision of such services is approved by the federal government. Recipients of state-funded services and persons who are determined to be functionally eligible for community-based services that have an application for medical assistance pending shall have the cost of home health and community-based services covered by the program, provided they comply with all medical assistance application requirements. Access agencies shall not use department funds to purchase community-based services or home health services from themselves or any related parties.

4. Regulations of Connecticut State Agencies § 17b-342-1 (c) (4) provides for category types. The following three category types define the funding sources which pay for the client's community based services and home health services. The category types apply to care managed cases, self-directed cases and the assisted living service program component. (A) Category Type 1: This category applies to elders who are at risk of institutionalization but who might not immediately enter a hospital or nursing facility in the absence of the program. This category type is available to elders who meet the financial and functional eligibility criteria for the state-funded portion of the program as defined in section 17b-10-1 of the Regulations of Connecticut State Agencies and the department's Uniform Policy Manual section 8040. Some clients under Category Type 1 may be Medicaid recipients because they do not meet the functional criteria for the Medicaid waiver portion of the program. (B) Category Type 2: This category applies to elders who would otherwise require admission to a nursing facility on a short or long term basis. This category type is available to elders who meet the financial and functional eligibility criteria for the state-funded portion of the program as defined in the department's Uniform Policy Manual section 8040. (C) Category Type 3: This category applies to elders who, but for the provision of home care services, would require nursing facility care funded by Medicaid. This category type is available to elders who meet the financial and functional eligibility criteria for Medicaid under the federal waiver as defined in the department's Uniform Policy Manual section 2540.92.

5. Uniform Policy Manual (“UPM”) Section 2540.92(A)(B) provides for eligibility criteria for individuals receiving home and community based services. This group 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. Individuals qualify for Medicaid as

categorically needy for as long as they meet the conditions above and receive home and community-based services under a waiver.

6. UPM § 2540.92 (C) provides for the income and asset criteria for individuals receiving home and community based services. 1. Except as described in subparagraph 3 below, the Department determines income eligibility under this coverage group by comparing the individual's gross income to the Special Categorically Needy Income Limit (CNIL), set at 300% of the maximum SSI amount for one person. To qualify as categorically needy, the individual's gross income must be less than the special CNIL. 2. Except as described in subparagraph 3 below, the Department uses the AABD asset limit to determine eligibility. 3. Individuals who are eligible for Medicaid under the "Working Individuals with Disabilities" coverage group, the "Severely Impaired" coverage group or the "Severely Impaired Non-SSI Recipients" coverage group, and who also meet the non-financial eligibility criteria described in paragraph A to receive home and community-based services under the Personal Care Assistance waiver, the Acquired Brain Injury waiver, the Department of Developmental Services Comprehensive waiver or the Department of Developmental Services Individual and Family Support waiver are considered to meet the income and asset criteria of this coverage group (Cross References: 2540.85, 2540.76 and 2540.77).

7. Connecticut General Statues 17b-261(c) provides that for the purposes of determining eligibility for the Medicaid program, an available asset is one that is actually available to the applicant or one that the applicant has the legal right, authority or power to obtain or to have applied for the applicant's general or medical support. If the terms of a trust provide for the support of an applicant, the refusal of a trustee to make a distribution from the trust does not render the trust an unavailable asset. Notwithstanding the provisions of this subsection, the availability of funds in a trust or similar instrument funded in whole or in part by the applicant or the applicant's spouse shall be determined pursuant to the Omnibus Budget Reconciliation Act of 1993, 42 USC 1396p.

   UPM § 4000.01 defines an "available asset" as "cash or any item of value which is actually available to the individual or which the individual has the legal right, authority or power to obtain, or to have applied for, his or her general or medical support.

   UPM § 4000.01 defines a counted asset as an asset which is not excluded and either available or deemed available to the assistance unit.

   UPM § 4000.01 defines non-home property as real property which a person owns but is not using as principal residence.

   UPM § 4000.01 defines real property as an asset in the form of real estate- that is, land and buildings, or campers, trailers or mobile homes which have been permanently affixed to the land.

   The Appellant's promissory note is not non-home property.

8. UPM § 4030.50 provides that mortgage notes, loans, installment contracts and similar financial instruments must be evaluated as both an asset representing an investment and as income that the beneficiary may receive on a regular basis (cross reference: 5050, Treatment of Specific Types). Also the right to receive income is regarded as an available asset.

   UPM § 4030.50 provides that the assistance unit's equity in a mortgage note, loan, installment contract or similar financial instrument is a counted asset to the extent that the assistance unit can sell or otherwise obtain the entire amount of equity in the investment.

   UPM § 3029.14(F) provides that notwithstanding any other provision of this paragraph, the Department evaluates a mortgage note, loan, installment contract or similar financial instrument, and the income stream derived from any such instrument, as an available asset.

   The Department correctly determined that the promissory note is an available asset.

9. UPM 4005.05 (A),(B)provides that the Department counts the unit's equity in an asset toward the asset limit if the asset is not excluded by state of federal law and is either: available to the assistance unit; or deemed available to the unit.

   UPM § 4005.05(D) provides that an assistance unit is not eligible for benefits under a particular program if the unit's equity in counted assets exceeds the asset limit for the particular program.

   UPM § 4005.10 provides that the Medicaid asset limit for a needs group of one is $1,600.00.

   UPM § 4005.15 provides that in the Medicaid program at the time of application, the assistance unit is ineligible until the first day of the month in which it reduces its equity in counted assets to within the asset limit.

   The Department correctly determined that the Appellant's promissory note valued at $41,725.00 exceeded the limits for Medicaid eligibility.

   The Department correctly denied the Appellant's LTC Medicaid application.

DISCUSSION

The Appellant's counsel argued that the asset is excluded because the Appellant is in the process of selling the note. He argued that the note is tied to the mortgage deed and that the mortgage deed is interest in real property. He stated that you can't sell the promissory note without selling the mortgage. The Department's definition of real property is an asset in the form of real estate- that is, land and buildings, or

campers, trailers or mobile homes which have been permanently affixed to the land. Promissory notes and mortgages are not real property.

The Appellant's counsel argued that the offers to purchase the note were submitted to the Department on [redacted] 2019 but the Department did not verify that the highest offer was acceptable for fair market value until [redacted] 2019 when the Appellant reapplied. Although there was a delay in notifying the Appellant regarding the fair market value of the highest offer, the Department had enough information to determine that the asset was available and in excess of the asset limit for the CHCP Medicaid Waiver program and thus deny the initial application.

DECISION

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

Thomas Monahan
Hearing Officer

C: Fred Presnick, Operations Manager, Bridgeport Regional Office
Yecenia Acosta, Operations Manager, Bridgeport Regional Office
Tim Latifi, Operations Manager, Bridgeport Regional Office
Shawn Hardy, Hearing Liaison

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 060105-3725.

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 06105-3725. 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.