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

Client ID #[redacted]
Case ID # [redacted]
Request # 162624

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2020, the Department of Social Services (the "Department") sent [redacted] (the "Applicant") a Notice of Action ("NOA") denying his medical assistance benefits under the Medicaid Home Care Waiver for Adults program within the eligibility requirements of the Medicaid for the Employed Disabled Program ("S05").

On [redacted] 2020, [redacted], the Applicant's Guardian, (the "Appellant") requested an administrative hearing to contest the Department's decision to deny such benefits.

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

On [redacted], 2020, 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 by telephone.

The following individuals participated in the hearing:

[redacted], Appellant, Applicant's Co-Guardian and mother

[redacted] Applicant's Co-Guardian and father
Jeanette Burney, Department's Representative
Marci Ostroski, Hearing Officer

The Applicant was not present at the administrative hearing.

The hearing record was left open for the submission of additional documentation, Exhibits were received from the Appellant and the record closed on [redacted] 2020.

STATEMENT OF THE ISSUE

The issue is whether the Department correctly denied the Appellant's Medicaid Home Care Waiver for Adults under the Medicaid for the Employed Disabled Program due to excess assets.

FINDINGS OF FACT

1. The Applicant was a recipient of Medicaid under the HUSKY C Medicaid for the Employed Disabled program until [redacted] 2019. (Ex. M: Case Notes; Department's testimony)

2. On [redacted] 2020, the Department received a W1E Application for Benefits signed by the Appellant on behalf of the Applicant and a request from the Department of Developmental Services ("DDS") requesting services in the Medicaid Home Care Waiver for Adults ("W01") under the Medicaid for the Employed Disabled Program ("S05"). (Ex. A: W1E Application for Benefits; Ex. M: Case Notes)

3. On the Application, the Applicant's assets consisted of a [redacted] checking account[redacted] a [redacted] checking account [redacted], and a life insurance policy through [redacted]. (Ex. A: W1E Application for Benefits)

4. The Applicant's [redacted] life insurance policy had a face value of $50,000 and a cash value of $12,694.51. (Hearing Summary)

5. On [redacted], 2020, the Department reviewed the Applicant's application and sent the Appellant a W1348LTC Verification We Need Form. The form requested the most recent bank statements from the two accounts with [redacted]. The form also stated "the cash surrender value of $12,694.51 for [redacted] policy counts toward the total asset limit of $1600. This puts the applicant over the asset limit, which means the policy may have to be cashed out, have a loan taken from it, be bought by another individual, or have the beneficiary of the policy signed over to a funeral home in order to purchase funeral contracts. Verification of how the funds are spent must be provided, and the funds must be spent on the applicant." The form further stated that "there is no eligibility for Title 19 Long Term Care benefits in any month in which counted assets exceed $1600. You must prove that your total assets are below $1600

and also show how your funds are spent to reduce your assets below the allowable limit. The due date for the requested verifications was [redacted] 2020, and the form stated that the Department would take action no later than [redacted] 2020. (Ex. B: Verification We Need #1)

6. The Department determined that the asset limit for the Applicant followed the S05 program and would therefore increase to $10,000 rather than $1600 under the W01 program. (Department's testimony)

7. The Department continued to send W1348 Verification We Need Forms to the Applicant requesting additional information on his assets. The Applicant continued to send verifications to the Department in compliance with the due dates provided. (Ex. M: Case Notes; Ex. C: Verification We Need #2; Ex D: Verification We Need #3; Ex. E: Verification We Need #4; Ex. F: Verification We Need #5; Ex. G: Verification We Need #6; Ex. H: Verification We Need #7; Ex. I: Verification We Need #8; Ex. J: Verification We Need #9)

8. On [redacted] 2020, the Department received verification from the Applicant that a loan for $3500 had been taken out of the cash value of the [redacted] life insurance policy. This was deposited into the Applicant's checking account on [redacted], 2020. The Department requested verification of how the $3500 was spent on the Applicant's behalf. (Ex. M: Case Notes)

9. On [redacted] 2020, the Department reviewed the verifications provided by the Applicant. The [redacted] life insurance policy cash value was verified to have been reduced to $9285.34. The Applicant's [redacted] account [redacted] was reflecting a balance as of [redacted] 2020, of $2145.77, and the Applicant's [redacted] account [redacted] was reflecting a balance as of [redacted] 2020, of $5021.88. the Appellant's total verified assets equaled $16452.99. (Ex. M: Case Notes)

10. On [redacted] 2020, the Department reviewed the verifications provided by the Applicant on [redacted] 2020, which consisted of receipts for purchased items. The Department sent a W1348LTC Verification we need requesting verification that the Applicant was under the asset limit of $10,000. (Ex. M: Case Notes)

11. On [redacted] 2020, the Department spoke with the Appellant via telephone. She confirmed verbally that the Applicant still exceeded the $10,000 asset limit. (Ex. M: Case Notes)

12. The Appellant's assets exceeded $10,000.00 from [redacted] 2020 through [redacted] 2020. (Hearing Record)

13. As of the date of the administrative hearing, the Applicant's assets still exceeded $10,000. (Appellant's testimony)

14. On [redacted] 2020, the Department sent the Applicant a Notice of Action denying the HUSKY C Medicaid stating that the "value of your assets is more than the amount we allow you to have". (Ex. N: Notice of Action [redacted]/20)

15. The issuance of this decision is timely under Connecticut General Statutes 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] 2020. This decision, therefore, was due no later than [redacted], 2020. However, the hearing record, which had been anticipated to close on [redacted], 2020, did not close for the admission of evidence until [redacted] 2020, at the Appellant's request. Because this 2-day delay in the close of the hearing record arose from the Appellant's request, this final decision was not due until [redacted], 2020, and is therefore timely. (Hearing Record)

CONCLUSIONS OF LAW

1. Section 17b-260 of the Connecticut General Statutes authorizes the Commissioner of the Department of Social Services to administer the Medicaid program.

2. "The department's Uniform Policy Manual ("UPM") is the equivalent of state regulation and, as such, carries the force of law." Bucchere v. Rowe, 43 Conn. Supp. 175, 178 (1994) (citing Conn. Gen. Stat. § 17b-10; Richard v. Commissioner of Income Maintenance, 214 Conn. 601, 573 A.2d 712 (1990)).

3. 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.

4. UPM § 3029.05 (B)(1) provides that the policy contained in this chapter pertains to institutionalized individuals and to their spouses.

5. UPM § 3029.05 (B)(2) An individual is considered institutionalized if he or she is receiving LTCF services; or services provided by a medical institution which are equivalent to those provided in a long-term care facility; or home and community-based services under a Medicaid waiver (cross references: 2540.64 and 2540.92).

6. UPM § 3029.05 (C) provides that the look-back date for transfers of assets is a date that is 60 months before the first date on which both the following conditions exist: the individual is institutionalized; and the individual is either applying for or receiving Medicaid.

7. The Department was correct when it determined that it must review assets for the Applicant for the 60 months immediately preceding his application for Medicaid waiver services.

8. 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.

9. UPM § 1015.10(A) provides that the Department must inform the assistance unit regarding the eligibility requirements of the programs administered by the Department, and regarding the unit's rights and responsibilities.

10. The Department correctly sent the Appellant application requirements lists requesting information needed to establish eligibility throughout the application process.

11. UPM § 3525.05(A)(c) provides in part for cooperation in the eligibility process that Applicants are responsible for cooperating with the Department in completing the application process by: providing and verifying information as required.

12. UPM § 1505.40(B)(5)(a) provides that for delays due to insufficient verification, regardless of the standard of promptness, no eligibility determination is made when there is insufficient verification to determine eligibility when the following has occurred: 1. the Department has requested verification; and 2. 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.

13. UPM § 1505.40(B)(5)(b) provides that additional 10-day extensions 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.

14. The Department correctly granted 10-day extensions for submitting verifications during the extension period up to the point that all verifications had been provided.

15. UPM § 1505.35(D)(2) provides that the Department determines eligibility within the standard of promptness for the AFDC, AABD, and MA programs except when verification needed to establish eligibility is delayed and one of the following is true: the client has good cause for not submitting verification by the deadline, or the client has been granted a 10-day extension to submit verification which has not elapsed.

16. The Department correctly made an eligibility determination once all verifications needed to establish eligibility had been provided.

17. Conn. Gen. Stat. § 17b-597 provides for a working persons with disabilities program. (a) The Department of Social Services shall establish and implement a working

persons with disabilities program to provide medical assistance as authorized under 42 USC 1396a(a)(10)(A)(ii), as amended from time to time, to persons who are disabled and regularly employed. (b) The Commissioner of Social Services shall amend the Medicaid state plan to allow persons specified in subsection (a) of this section to qualify for medical assistance. The amendment shall include the following requirements: (1) That the person be engaged in a substantial and reasonable work effort as determined by the commissioner and as permitted by federal law and have an annual adjusted gross income, as defined in Section 62 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, of no more than seventy-five thousand dollars per year; (2) a disregard of all countable income up to two hundred per cent of the federal poverty level; (3) for an unmarried person, an asset limit of ten thousand dollars, and for a married couple, an asset limit of fifteen thousand dollars; (4) a disregard of any retirement and medical savings accounts established pursuant to 26 USC 220 and held by either the person or the person's spouse; (5) a disregard of any moneys in accounts designated by the person or the person's spouse for the purpose of purchasing goods or services that will increase the employability of such person, subject to approval by the commissioner; (6) a disregard of spousal income solely for purposes of determination of eligibility; and (7) a contribution of any countable income of the person or the person's spouse which exceeds two hundred per cent of the federal poverty level, as adjusted for the appropriate family size, equal to ten per cent of the excess minus any premiums paid from income for health insurance by any family member, but which does not exceed the maximum contribution allowable under Section 201(a)(3) of Public Law 106-170, as amended from time to time.

18. UPM § 2540.85 provides there are two distinct groups of employed individuals between the ages of 18 and 64 inclusive who have a medically certified disability or blindness and who qualify for Medicaid as working individuals with disabilities. These groups are the Basic Insurance Group and the Medically Improved Group. There is a third group of employed individuals consisting of persons at least 18 years of age who have a medically certified disability or blindness who also qualify for Medicaid as working individuals with disabilities. This is the Balanced Budget Act Group. Persons in this third group may be age 65 or older.

19. UPM § 2540.85(A) provides for the Basic Insurance Group. An individual in this group, which is authorized under the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), is subject to the conditions described below. 1. An individual in this group must be engaged in a substantial and reasonable work effort to meet the employment criterion. (a) Such effort consists of an activity for which the individual receives cash remuneration and receives pay stubs from his or her employer. (b) If the individual is self-employed, he or she must have established an account through the Social Security Administration and must make regular payments based on earnings as required by the Federal Insurance Contributions Act. (c) that an individual who meets the employment criterion but then loses employment through no fault of his or her own, for reasons such as a temporary health problem or involuntary termination, continues to meet the employment criterion for up to one year from the

date of the loss of employment. The individual must maintain a connection to the labor market by either intending to return to work as soon as the health problem is resolved, or by making a bona fide effort to seek employment upon an involuntary termination.

20. The Department correctly evaluated the Applicant's eligibility under the Basic Insurance Group for the working persons with disabilities program.

21. UPM § 4005.10 (A)(5)(a) provides for Treatment of Assets; Asset Limits For All Programs: MAABD-Working Individuals with Disabilities; The asset limit is $10,000 for a single individual.

22. UPM § 4005.05 (B) (1) provides that the Department counts the assistance unit's equity in an asset toward the asset limit if the asset is not excluded by state or federal law and is either: available to the unit; or deemed available to the assistance unit.

23. UPM § 4030 provides that the Department evaluates all types of assets available to the assistance unit when determining the unit's eligibility for benefits.

24. UPM § 4030.05 provides in part for Treatment of Assets; Treatment of Specific Types: checking and savings bank accounts are considered counted assets.

25. UPM § 4030.30(C) provides for Treatment of Assets; Treatment of Specific Types: Life Insurance Policies; If the total face value of all life insurance policies owned by the individual does not exceed $1,500, the cash surrender value of such policies is excluded. In computing the face value of life insurance, the Department does not count insurance such as term insurance which has no cash surrender value. 2. Except as provided above, the cash surrender value of life insurance policies owned by the individual is counted towards the asset limit.

26. The Department correctly counted the value of the Applicant's life insurance policy cash value toward the asset limit.

27. Connecticut General Statutes 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, 42USC 1396p.

28. UPM § 4005.05 (B) (2) provides that under all programs except Food Stamps, the Department considers an asset available when actually available to the individual

or when the individual has the legal right, authority, or power to obtain the asset or to have it applied for, his or her general or medical support.

29. 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.

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

31. The Department correctly determined that the bank accounts and life insurance policy cash value were countable and accessible assets for the Appellant.

32. The Department correctly determined the Appellant's assets exceeded the Medicaid asset limit of $10,000.00 in each month throughout the application period of [redacted] 2020 through [redacted] 2020 and correctly denied the Appellant's Home Care Waiver benefits under the S05 program for [redacted] 2020 through [redacted] 2020.

DISCUSSION

The Department and the Appellant were both in agreement that the Applicant's assets exceeded the limit of $10,000 throughout the application period. The Department's denial of Medicaid benefits for exceeding the asset limit is correct.

The Appellant did dispute the timing of the denial, however, and felt that the application should have remained pending while they continued to spend down assets. This action would not benefit the Applicant as the regulations are clear that Medicaid is denied for every month in which the asset limit is exceeded. Even if the Department did continue the application process, the months back to the application date would still be denied.

The Department is required to process Medicaid applications within a standard of promptness. The Department was able to exceed the 90-day standard of promptness for the Applicant's Medicaid application while additional verifications were still required. The Department is authorized to allow extensions of time for the Applicant to provide all necessary documentation of eligibility. Once all the verifications were provided and no further extensions were necessary, the Department is required by regulations to make an eligibility determination. The Department is unable to keep the application pending indefinitely.

In the Appellant's hearing arguments, she stated that the Department's actions to deny the Applicant's Medicaid application were arbitrary and capricious. I did not find any evidence that the Department's actions were arbitrary or capricious. The Department made an eligibility determination based solely on the exact dollar amount of his assets based on the state statutes and regulations, and that they did so when regulations no longer allowed any further extensions of the application process.

The Appellant further argued that the Department's denial of benefits was an abuse of authority precluding the Applicant's right to due process. I did not find any evidence that the Applicant's due process rights were compromised. The Department did provide a Notice of Action to the Applicant at denial with hearing rights. The Appellant was able to request and attend the administrative hearing and present her testimony and exhibits.

From the beginning of the application process, the Department communicated the eligibility requirements of the Medicaid program. The Verification We Need Form stated that there is no eligibility for Title XIX Long Term Care benefits in any month in which counted assets exceed the asset limit.

The Appellant was in agreement that the Applicant's assets exceeded the asset limit of $10,000 throughout the application process. She is encouraged to reapply once he falls below the statutory threshold of $10,000 for the S05 program.

DECISION

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

Marci Ostroski
Hearing Officer

CC: Judy Williams, Musa Mohamud, Jessica Carroll Operations Managers, Greater Hartford RO
Jeanette Burney, 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 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, 165 Capitol Avenue, 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.