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

[redacted] **2016**
Signature Confirmation

Request # 765336
Client ID # [redacted]

NOTICE OF DECISION

PARTY

[redacted]
c/o [redacted]
[redacted]
[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2016, the Department of Social Services (the "Department") sent [redacted] (the "Appellant") a Notice of Action ("NOA") discontinuing his Medicaid for the Employed Disabled benefits because he did not make the required premium payments.

On [redacted] 2016, the Appellant, by his authorized representative, requested an administrative hearing to appeal the Department's decision to discontinue his Medicaid benefits.

On [redacted] 2016, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2016.

On [redacted] 2016, 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] Appellant's authorized representative
Joseph Alexander, Department's Representative
Jessica Gulianello, Department's Representative
James Hinckley, Hearing Officer

The hearing record was held open for the Appellant's authorized representative to provide billing and payment records. On [redacted] 2016, the hearing record closed.

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department was correct to discontinue the Appellant's Medicaid for the Employed Disabled benefits effective [redacted] 2016 due to outstanding unpaid premiums.

FINDINGS OF FACT

1. The Appellant has historically received benefits from the Medicaid for the Employed Disabled program for months prior to [redacted] 2015, and has received benefits continuously at least since [redacted] 2015. (Ex. 5: MA Financial Eligibility screens, Ex. 6: Medicaid For Employed Disabled Premiums screens)

2. Between [redacted] 2015 and [redacted] 2015, the Appellant's premiums for the program were assessed as follows: [redacted] 2015 - $22.63, [redacted] 2015 - $22.63, [redacted] 2015 - $21.03, [redacted] 2015 - $21.03, [redacted] 2015 - $21.03, [redacted] 2015 - $21.03, [redacted] 2015 - $21.03, [redacted] 2015 - $34.12, [redacted] 2015 - $34.12; total premiums for [redacted] 2015 to [redacted] 2015, $239.68. (Ex. 5, Ex. 6)

3. Between [redacted] 2015 and [redacted] 2015, the Appellant's authorized representative made premium payments as follows (check posting date from Appellant's bank records listed): [redacted] 2015 - $21.05, [redacted] 2015 - $22.63, [redacted] 2015 - $21.03, [redacted] 2015 - $21.03, [redacted] 2015 - $21.03, [redacted] 2015 - $21.03, [redacted] 2015 - $21.03, [redacted] 2015 – $21.03, [redacted] 2015 - $34.12, [redacted] 2015 - $34.12; the total premiums paid by the Appellant between [redacted] 2015 and [redacted] 2015 was $238.10 (Ex. A: Appellant's authorized representative's billing and payment records)

4. Between [redacted] 2015 and [redacted] 2015, the Appellant's premium payments were short by $1.58 ($239.68, minus $238.10). (Facts #2 and #3)

5. On [redacted] 2015, the Department issued a Premium Invoice to the Appellant's authorized representative; the invoice stated that the [redacted] 2015 premium was $26.14, and that the "Current Balance" and the "Total Due" was $13.05. (Ex. A, [redacted] 2013 Premium Invoice)

6. In [redacted] 2015, the Appellant's authorized representative made a premium payment in the amount of $13.05, and the check cleared on [redacted] 2015. (Ex. A)

7. The [redacted] 2015 premium amount of $26.14 as stated on the Premium Invoice was the correct premium amount owed for [redacted] 2015. (Ex. 5: MA Financial Eligibility screen for [redacted] 2015, Ex. 6: Medicaid For Employed Disabled Premiums screen, Fact #5)

8. The Appellant's authorized representative's $13.05 premium payment for [redacted] 2015 was short by $13.09 ($26.14 premium, minus $13.05 payment). (Facts #6 and #7)

9. Between [redacted] 2015 and [redacted] 2016, the Appellant's premiums for the program were assessed as follows: [redacted] 2015 - $26.14, [redacted] 2016 - $26.14, [redacted] 2016 - $26.14, [redacted] 2016 - $24.34, [redacted] 2016 - $24.34; total premiums for [redacted] 2015 to [redacted] 2016, $127.10. (Ex. 5, Ex. 6)

10. Between [redacted] 2015 and [redacted] 2016, the Appellant's authorized representative made premium payments as follows (check posting date from Appellant's bank records listed): [redacted] 2015 - $26.14, [redacted] 2016 - $26.14, [redacted] 2016 - $26.14, [redacted] 2016 – 24.34, [redacted] 2016 - $22.54; the total premiums paid by the Appellant between [redacted] 2015 and [redacted] 2016 was $125.30. (Ex. A)

11. Between [redacted] 2015 and [redacted] 2016, the Appellant's premium payments were short by $1.80 ($127.10, minus $125.30). (Ex. 1)

12. The Appellant's premium payments have been in arrears since [redacted] 2015, and the Appellant never became current with his premium payments. (Facts #2 through #11)

13. On [redacted] 2016, the Department sent the Appellant a NOA advising him that his Medical Assistance would be discontinued effective [redacted] 2016 because he did not make his premium payment by the due date, and that he would be ineligible until any past due amount was paid in full. (Ex. 2: [redacted] 2016 NOA)

CONCLUSIONS OF LAW

1. Section 17b-2 and § 17b-260 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. Uniform Policy Manual ("UPM") § 2540.85 provides for the eligibility requirements for Medicaid for Working Individuals with Disabilities

   UPM § 2540.85(A)(4) provides in part that individuals who qualify for Medicaid as working individuals with disabilities may be required to pay the Department a monthly premium for medical coverage if the gross monthly counted income of the individual and spouse (minus Impairment-Related Work Expenses described at UPM 5035.10 C) exceeds 200% of the federal poverty level (FPL) for the appropriate family size, including dependent children living in the home.

   The Department was correct to discontinue the Appellant's Medicaid for the Employed Disabled benefits effective [redacted] 2016 because the required premium payments for the program were in arrears.

DISCUSSION

The Medicaid for the Employed Disabled program provides medical assistance to disabled individuals who maintain employment. Beneficiaries of the program are charged premiums based on their earnings and other factors, and the premiums are subject to change when household circumstances change. One of the core eligibility requirements of the program is that premium payments must be kept current, and discontinuance can result if the premiums fall into delinquency. If coverage lapses, it cannot be reinstated until all past due premiums are brought current.

Much of the hearing focused on the adequacy (or inadequacy) of the Department's billing, payment and notification processes, and the discrepancies that arose when the Appellant's authorized representative tried to reconcile her records with the Department's. The representative keeps accurate records but was not always able to match her figures with the notices she received, or with information she received over the telephone.

Despite any misunderstandings, miscommunications or confusion, in the end, the eligibility requirement for the program is that the premiums *actually assessed* by the Department must be paid. When the Appellant's authorized representative, in good faith, paid $13.05 in [redacted] 2015 because it represented the "Amount Due" stated on the [redacted] invoice, it was $13.09 short of the actual [redacted] premium that was due. The issue of this hearing is not to assign blame to one

party or the other for the confusion. The issue of the hearing is to determine whether the Appellant was actually eligible or not eligible when the Department discontinued his case effective [redacted] 2016. The Appellant's premiums were not fully paid up as of [redacted] 2016, so the Department was correct when it discontinued his case.

I wish to note something the Appellant's representative said in a letter included with her billing and payment records which indicates to me that some additional confusion may exist. In the letter she stated in part, "It would behoove all parties involved for Med-Connect to acknowledge the errors in billing and ***allow*** [redacted] ***to pay the $13.09*** that is in reality the result of an incorrect [redacted] 2015 invoice and not a deliberate or even an unintentional non-payment of premium. The invoice should have reflected $26.14 but HUSKY billed $13.05". (emphasis added)

To be clear, the Appellant does not need a hearing decision to *allow* him to pay the premiums he owes. All the Appellant ever had to do to regain his eligibility for the program was to catch up on his premiums. This decision simply affirms that this is still true. The Appellant will be eligible for the program again as soon as he becomes current with all premiums owed.

DECISION

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

James Hinckley
Hearing Officer

cc: Poonam Sharma, SSOM, Bridgeport
Fred Presnick, SSOM, Bridgeport
Yecenia Acosta, SSPM, Bridgeport

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, law, and 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.

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, if 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.