

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

██████████ 2016  
Signature Confirmation

Client ID # ██████████  
Request # 777330

**NOTICE OF DECISION**

**PARTY**

██████████  
██████████  
████████████████████

**PROCEDURAL BACKGROUND**

On ██████████ 2016, the Department of Social Services (the "Department") sent ██████████ (the "Appellant") a Notice of Action ("NOA") discontinuing her medical benefits under the Medicaid for Employees with Disabilities effective ██████████ 2016.

On ██████████ 2016, the Appellant requested an administrative hearing to contest the Department's decision to discontinue such benefits.

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

On ██████████ 2016, 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:

██████████ Appellant  
██████████ Intercommunity Agency, Witness for the Appellant  
Marc Blake, Department Representative  
Lisa Nyren, Fair Hearing Officer

## **STATEMENT OF THE ISSUE**

The issue to be decided is whether the Department's decision to discontinue the Appellant's medical benefits under the Medicaid for Employees with Disabilities was correct.

## **FINDINGS OF FACT**

1. The Appellant is a recipient of Medicaid for Employees with Disabilities ("Med-Connect") program. (Hearing Record)
2. On [REDACTED] 2015, the Department issued the Appellant a notice of action. The Department determined the monthly premium under the Med-Connect program as \$28.45 effective [REDACTED] 2015 and continuing unless a change occurs in your income. (Exhibit F: Notice of Action [REDACTED]/15)
3. On [REDACTED] 2015, the Department issued a notice of action to the Appellant. The notice instructed the Appellant to mail a check or money order for the premium payment of \$28.45 under the Med-Connect program to the Commissioner of Social Services in the enclosed envelope. Payment is due [REDACTED] 2015. (Exhibit E: Premium Payment Invoices)
4. On [REDACTED] 2015, the Appellant issued personal check #2992 to the Commissioner of Social Services for \$28.45 for Med-Connect Premium due [REDACTED] 2015. (Exhibit G: Cancelled Checks and Appellant's Testimony)
5. On [REDACTED] 2015, the Department received August 2015 Med-Connect premium payment from the Appellant for \$28.45, check #2992. (Exhibit G: Cancelled Checks and Appellant's Testimony)
6. On [REDACTED] 2015, the Department issued premium invoice #441 to the Appellant requesting payment for [REDACTED] 2015 Med-Connect program premium payment due [REDACTED] 2015 for \$28.45. The invoice lists current balance as \$28.45 and total due \$28.45. (Exhibit E: Premium Payment Invoices and Exhibit D: Statement of Account)
7. On [REDACTED] 2015, the Appellant issued personal check #3003 to the Commissioner of Social Services for \$28.45 for Med-Connect Premium due [REDACTED] 2015. (Exhibit G: Cancelled Checks and Appellant's Testimony)
8. On [REDACTED] 2015, the Department received [REDACTED] 2015 Med-Connect premium payment from the Appellant for \$28.45, check # 3003.

(Exhibit 4: Premium Invoices, Exhibit G: Cancelled Checks and Appellant's Testimony)

9. On [REDACTED] 2015, the Department issued premium invoice #1433 to the Appellant requesting payment for [REDACTED] 2015 Med-Connect program premium payment due [REDACTED] 2015 for \$28.45. The invoice lists current balance as \$28.45 and total due \$28.45. The invoice confirms receipt of [REDACTED] 2015-premium payment of \$28.45. (Exhibit E: Premium Payment Invoices and Exhibit D: Statement of Account)
10. On [REDACTED] 2015, the Appellant issued personal check # 3011 to the Commissioner of Social Services for \$28.45 for Med-Connect premium due [REDACTED] 2015. (Exhibit G: Cancelled Checks and Appellant's Testimony)
11. On [REDACTED] 2015, the Department received October 2015 Med-Connect premium payment from the Appellant for \$28.45, check # 3011. (Exhibit 4: Premium Invoices, Exhibit G: Cancelled Checks and Appellant's Testimony)
12. On [REDACTED] 2015, the Department issued premium invoice #2216 to the Appellant requesting payment for [REDACTED] 2015 Med-Connect program premium payment due [REDACTED] 2015 for \$49.63. The invoice lists current balance as \$49.63 and total due \$49.63. The invoice confirms receipt of [REDACTED] 2015-premium payment of \$28.45. (Exhibit E: Premium Payment Invoices and Exhibit D: Statement of Account)
13. On [REDACTED] 2015, the Appellant issued personal check # 3016 to the Commissioner of Social Services for \$49.63 for Med-Connect premium due [REDACTED] 2015. (Exhibit G: Cancelled Checks and Appellant's Testimony)
14. On [REDACTED] 2015, the Department received November 2015 Med-Connect premium payment from the Appellant for \$49.63, check # 3016. (Exhibit 4: Premium Invoices, Exhibit G: Cancelled Checks and Appellant's Testimony)
15. On [REDACTED] 2015, the Department issued premium invoice #2877 to the Appellant requesting payment for [REDACTED] 2015 Med-Connect program premium payment due [REDACTED] 2015 for \$60.81. The invoice confirms receipt of November 2015-premium payment of \$49.63. (Exhibit E: Premium Payment Invoices and Exhibit D: Statement of Account)
16. On [REDACTED] 2015, the Appellant issued personal check # 3027 to the Commissioner of Social Services for \$60.81 for Med-Connect premium

- due [REDACTED] 2015. (Exhibit G: Cancelled Checks and Appellant's Testimony)
17. On [REDACTED] 2015, the Department received [REDACTED] 2015 Med-Connect premium payment from the Appellant for \$60.81, check # 3027. (Exhibit G: Cancelled Checks and Appellant's Testimony)
  18. On [REDACTED] 2016, the Department issued premium invoice #3525 to the Appellant requesting payment for [REDACTED] 2016 Med-Connect program premium payment due [REDACTED] 2016 for \$60.81. The invoice lists current balance as \$60.81 and total due as \$60.81. The invoice confirms receipt of December 2015-premium payment of \$60.81. (Exhibit E: Premium Payment Invoices and Exhibit D: Statement of Account)
  19. On [REDACTED] 2016, the Appellant issued personal check # 3032 to the Commissioner of Social Services for \$60.81 for Med-Connect premium due [REDACTED] 2016. (Exhibit G: Cancelled Checks and Appellant's Testimony)
  20. On [REDACTED] 2016, the Department received January 2015 Med-Connect premium payment from the Appellant for \$60.81, check # 3032. (Exhibit 4: Premium Invoices, Exhibit G: Cancelled Checks and Appellant's Testimony)
  21. On [REDACTED] 2016, the Department issued premium invoice # 4151 to the Appellant requesting payment for February 2016 Med-Connect program premium payment due [REDACTED] 2016 for \$60.81. The invoice lists current balance as \$60.81 and total due as \$60.81. The invoice confirms receipt of [REDACTED] 2016-premium payment of \$60.81. (Exhibit E: Premium Payment Invoices)
  22. On [REDACTED] 2016, the Appellant issued personal check # 3038 to the Commissioner of Social Services for \$60.81 for Med-Connect premium due [REDACTED] 2016. (Exhibit G: Cancelled Checks and Appellant's Testimony)
  23. On [REDACTED] 2016, the Department received [REDACTED] 2016 Med-Connect premium payment from the Appellant for \$60.81, check # 3038. (Exhibit 4: Premium Invoices, Exhibit G: Cancelled Checks and Appellant's Testimony)
  24. On [REDACTED] 2016, the Department issued premium invoice # 4299 to the Appellant requesting payment for [REDACTED] 2016 Med-Connect program premium payment due [REDACTED] 2016 for \$59.01. The invoice lists current balance as \$59.01 and total due \$59.01. The invoice voids the [REDACTED] 2016 Med-Connect premium of \$60.81 billed on

- ██████████ 2016. (Exhibit E: Premium Payment Invoices and Exhibit D: Statement of Account)
25. The Appellant overpaid the ██████████ 2016 Med-Connect premium of \$59.01 by \$1.80. [\$59.01 ████████/16 premium - \$60.81 ████████/16 premium paid = (-\$1.80)] (Exhibit 4: Premium Invoices and Appellant's Testimony)
  26. On ██████████ 2016, the Department issued premium invoice # 4882 to the Appellant requesting payment for ██████████ 2016 Med-Connect program premium payment due ██████████ 2016 for \$59.01. The invoice lists the ██████████ 2016 premium payment as outstanding. The invoice lists current balance as \$59.01 and total due as \$118.02, which includes an outstanding ██████████ 2016 premium balance of \$59.01. (Exhibit E: Premium Payment Invoices and Exhibit D: Statement of Account)
  27. On ██████████ 2016, the Appellant issued personal check # 3049 to the Commissioner of Social Services for \$59.01 for Med-Connect premium due ██████████ 2016. (Exhibit G: Cancelled Checks and Appellant's Testimony)
  28. On ██████████ 2016, the Department received ██████████ 2016 Med-Connect premium payment from the Appellant for \$59.01, check #3049. (Exhibit 4: Premium Invoices, Exhibit G: Cancelled Checks and Appellant's Testimony)
  29. Beginning ████████ 2016, the Department determined the Appellant's Med-Connect premium as \$00.00. (Hearing Record)
  30. On ██████████ 2016, the Department issued a notice of discontinuance to the Appellant. The notice stated the Appellant did not make a premium payment by the due date and ineligible for benefits until any past due amount is paid in full. Benefits will end on ██████████ 2016. (Exhibit 2: Notice of Action)
  31. On ██████████ 2016, the Department reversed its decision to discontinue benefits and rescreened Med-Connect benefits effective ██████████ 2016. The Appellant continued under the Med-Connect program with no loss of benefits. (Exhibit 1: Case Narrative, Exhibit A: Notice of Action, and Exhibit B: Notice of Action)
  32. The Department determined the Appellant owes a delinquent premium amount of \$21.18 under the Med-Connect program. (Exhibit 7: Medicaid for Employed Disabled Premium)
  33. On ██████████ 2016, the Department issued a notice of discontinuance to the Appellant. The notice stated the Appellant did not make a premium

payment by the due date and ineligible for benefits until any past due amount is paid full. Benefits will end on [REDACTED] 2016. (Exhibit 3: Notice of Action)

### CONCLUSIONS OF LAW

1. Connecticut General Statute § 17b-2(6) provides that the Department of Social Services is designated as the state agency for the administration of the Medicaid program pursuant to Title XIX of the Social Security Act.
2. Uniform Policy Manual (“UPM”) § 2540.85 provides that 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 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.
3. UPM § 2540.85(A)(4) provides that the individual 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 5035.10C) exceeds 200% of the federal poverty level (FPL) for the appropriate family size, including dependent children living in the home.

UPM § 5045.21(A) provides that an individual eligible for Medicaid under the Working Individuals with Disabilities coverage group may be required to pay a monthly premium for Medicaid coverage if the gross counted income of the individual and his or her spouse, minus Impairment Related Work Expenses (IRWE’s), exceeds 200% of the federal poverty level for the appropriate family size. (Cross Reference 2540.85)

4. The Appellant correctly paid the monthly S05 premiums as billed by the Department timely resulting in a credit totaling \$1.80 for the period [REDACTED] 2015 through [REDACTED] 2016.

Month	Invoice #	Billed	Check #	Paid
[REDACTED]/15	n/a	\$28.45	2992	\$28.45
[REDACTED]/15	441	\$28.45	3003	\$28.45
[REDACTED]/15	1433	\$28.45	3011	\$28.45
[REDACTED]/15	2216	\$49.63	3016	\$49.63
[REDACTED]/15	2877	\$60.81	3027	\$60.81

█/16	3525	\$60.81	3032	\$60.81
█/16	4151	(\$60.81)		
█/16 revised	4299	\$59.01	3038	\$60.81
█/16	4882	\$59.01	3049	\$59.01
Totals		\$374.62		\$376.42

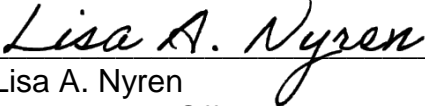
5. UPM §1565.05(A)(2) provides that when eligibility has been determined to no longer exist, the last day for which the assistance unit is entitled to the benefits of the program is: the last day of the month in which a nonfinancial eligibility factor causes ineligibility, provided that eligibility had existed on the first of the month. This includes death of a recipient.
6. On █ █ 2016, the Department incorrectly discontinued the Appellant's Med-Connect medical program effective █ 2016 for non-payment of monthly premium. The Appellant paid her monthly premiums timely. The Appellant has a credit of \$1.80 not a deficit of \$21.18.

### DECISION

The Appellant's appeal is granted.

### ORDER

1. The Department must reinstate the Appellant's medical benefits under the Med-Connect Program effective █ 2016 with no loss of eligibility.
2. The Department must remove any unpaid premium balance for the period █ 2015 through █ 2016 and refund the Appellant for overpaid premiums.
3. Compliance is due █ 2016.

  
 Lisa A. Nyren  
 Fair Hearing Officer

CC: Musa Mohamud, Social Services Operations Manager  
 Judy Williams, Social Services Operations Manager  
 Tricia Morelli, Social Services Program Manager  
 Marc Blake, Fair 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, 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.