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

[redacted] **2016**
Signature Confirmation

CL ID # [redacted]
Hearing Request # 782976

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2016, the Department of Social Services (the "Department") sent a notice to [redacted] (the "Appellant") advising that he was ineligible for Medicare Savings Program ("MSP") benefits.

On [redacted] 2016, the Appellant requested an administrative hearing because he disagreed with the Department's decision to discontinue such 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, 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], the Appellant,
[redacted] the Appellant's spouse
Elsie Fowler, Eligibility Worker, DSS, Willimantic Regional Office
Maureen Foley-Roy, Hearing Officer

The hearing record was held open for the submission of additional evidence. On [redacted] 2016, the record closed.

This decision pertains solely to the Medicare Savings Program benefits. A decision regarding HUSKY medical assistance will be issued separately.

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department's decision to discontinue the Appellant's benefits through the Medicare Savings Program effective [redacted] 2016 was correct.

FINDINGS OF FACT

1. The Appellant and his wife were recipients of HUSKY A Medicaid through [redacted] 2016 because they had a minor child in their home. They no longer have any minor children in their home. (Hearing record and Appellant's testimony)

2. The Appellant is a recipient of Social Security Disability benefits in the amount of $485.90 per month. (Exhibits 11: Bendex Inquiry)

3. The Appellant is a recipient of Medicare A and B. A monthly premium of $105.90 is deducted from his Social Security benefit for Medicare. (Exhibit 12: Bendex Benefit Screen Print)

4. The Appellant's wife is employed at a plant in [redacted]. She drives to her job five days a week and it takes her approximately 40 minutes to get there. She is unsure how many miles she drives. (Appellant's testimony)

5. The Social Security benefit and his wife's earnings are the couple's only income. (Appellant's testimony)

6. The Appellant's wife has dental, vision and life insurance premiums deducted from her paycheck. (Exhibit 2: Paystubs)

7. The Appellant's wife has a deduction from her paycheck to a 401K but it is not mandatory.(Exhibit 2 & Appellant's testimony)

8. The Appellant's wife is not in a union and all equipment that she needs on her job is supplied by her company. (Appellant's testimony)

9. On [redacted] 2016, the Department issued a notice advising the Appellant that MSP benefits were discontinued because his household's income exceeded the program's limit. (Exhibit 4: Notice of Discontinuance dated [redacted] 2016)

CONCLUSIONS OF LAW

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

2. Federal Statutes provide for the definition of a qualified Medicare beneficiary as an individual: Who is entitled to hospital insurance benefits under part A of subchapter XVIII of this chapter (including an individual entitled to such benefits pursuant to an enrollment under section 1395I-2 of this title, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1351I-2a of this title.) [42 United States Code (U.S.C.) § 1396d(p)(1)(A)] whose income (as determined under section 1382(a) of this title for purposes of the supplemental security income program, except as provided in paragraph 2(D) does not exceed an income level established by the state consistent with paragraph 2. [42 U.S.C. § 1396d(p)(1)(B)]

3. Section 17b-256(f) of the Connecticut General Statutes provides for the Medicare Saving Program Regulations and states in part that beginning in March of 2012 and annually thereafter the Commissioner of Social Services shall increase income disregards used to determine eligibility by the Department of Social Services for the federal Qualified Medicare Beneficiary, the Specified Low-Income Medicare Beneficiary and the Qualifying Individual programs, administered in accordance with the provisions of 42 USC 1396d(p), by such amounts that shall result in persons with income that is (1) less than two hundred eleven per cent of the federal poverty level qualifying for the Qualified Medicare Beneficiary program, (2) at or above two hundred eleven per cent of the federal poverty level but less than two hundred thirty-one per cent of the federal poverty level qualifying for the Specified Low-Income Medicare Beneficiary program, and (3) at or above two hundred thirty-one per cent of the federal poverty level but less than two hundred forty-six per cent of the federal poverty level qualifying for the Qualifying Individual program. The commissioner shall not apply an asset test for eligibility under the Medicare Savings Program. The commissioner shall not consider as income Aid and Attendance pension benefits granted to a veteran, as defined in section 27-103, or the surviving spouse of such veteran. The Commissioner of Social Services, pursuant to section 17b-10, may implement policies and procedures to administer the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided the commissioner prints notice of the intent to adopt the regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Such policies and procedures shall be valid until the time final regulations are adopted.

4. Uniform Policy Manual (“UPM”) § 2540.94(A)(1) a provides for Qualified Medicare Beneficiaries (“QMB”) coverage group to include individuals who are entitled to hospital insurance benefits under part A of Title XVIII of the Social Security act;

5. UPM § 2540.94 D 1 provides in part that the Department uses the Aid to the Aged, Blind or Disabled Program ("AABD") income criteria, including deeming methodology, to determine eligibility for this coverage group.

6. UPM § 5020.75 C 5,6, and 7 provides for the deeming methodology and states that deemed income is calculated from parents and from spouses in the same way for members of the Qualified Medicare Beneficiaries, Specified Low Income Medicare Beneficiaries and Additional Low Income Medicare Beneficiaries coverage groups as in AABD.

7. UPM § 2015.05(A) provides that the assistance unit in AABD and MAABD consists of only one member. In these programs, each individual is a separate assistance unit.

8. UPM § 5020.70 A 1 provides that the Department deems the income of the spouse of an AABD recipient if they are considered to be living together.

9. The Department was correct when it determined that his wife's income must be deemed to the Appellant.

10. UPM § 5020.70 C 3 provides for calculating the amount of deemed income and states that the when the spouse has not applied for AABD or has applied and been determined to be ineligible for benefits, the amount deemed to the unit from the unit member's spouse is calculated in the following manner: the deemor's self-employment earnings are reduced by self-employment expenses, if applicable, and the **deemor's gross earnings are reduced by deducting the following personal employment expenses, as appropriate, (1) mandatory union dues and costs of tools, materials, uniforms or other protective clothing when necessary for the job and not covered by the employer, (2) proper federal income tax based upon the maximum number of deductions to which the deemor is entitled, (3) FICA, group life insurance, health insurance premiums, or mandatory retirement plans, (4) lunch allowance at .50 per working day,(5) transportation allowance to travel to work at the cost per work day as charged by private conveyance or at .12 cents per mile by private car or in a car pool.** Mileage necessary to take children to or pick them up from a child care provider may also be included. (Emphasis added)

11. The Department was incorrect when it deemed the Appellant's spouse's earned income without reducing the income by her personal employment expenses.

12. The Appellant's eligibility for Medicare Savings Program benefits cannot be determined because the Department did correctly deem the Appellant's spouse's earnings.

DISCUSSION

The regulations and Department's policy require that the spouse's earnings be reduced by specific deductions, unique in every case. In this particular case, the Department must request that the Appellant determine how many miles his spouse drives to work in order to reduce her earnings by a mileage deduction. Other deductions include federal taxes, medical and life insurance premiums (which can be found on the spouse's paystub) and even a deduction for lunch each day. All of the allowable deductions must be applied to the spouse's earnings in order to calculate the correct amount of deemed income.

DECISION

The Appellant's appeal is **REMANDED BACK TO THE DEPARTMENT FOR FURTHER ACTION.**

ORDER

The Department is ordered to obtain the number of miles the Appellant's spouse drives to work and recalculate the deemed income by allowing all of the deductions noted in the COL #10 above to the Appellant's spouse's earnings. The Department shall then determine the Appellant's eligibility for the Medicare Savings Program at any level. Compliance with this order is due by [redacted] 2016 and shall consist of documentation that the Department has determined eligibility for the Medicare Savings program using the correctly deemed income.

Maureen Foley-Roy

Maureen Foley-Roy
Hearing Officer

CC: Tonya Cook-Bedford, Social Service Operations Manager, Willimantic
Elsie Fowler, Eligibility Worker, Willimantic

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.