**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 # 796374**

## NOTICE OF DECISION

## PARTY

[redacted]

## PROCEDURAL BACKGROUND

On [redacted] 2016, the Department of Social Services (the "Department") sent a notice to [redacted] (the "Appellant") notifying her that she is eligible for Medicare Savings Program, also known as the Qualified Medicare Beneficiaries program("QMB") effective [redacted] 2016.

On [redacted] 2016, the Appellant requested an administrative hearing because she disagreed with the Department's decision to grant QMB effective [redacted] 2016.

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,
Joseph Alexander, Department's Representative
Swati Sehgal, Hearing Officer

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

## STATEMENT OF THE ISSUE

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

## FINDINGS OF FACT

1. The Appellant and her children are recipients of HUSKY A Medicaid. (Hearing record and Appellant's testimony)

2. The Appellant is a recipient of Social Security Disability benefits in the amount of $1128.20 per month. (Exhibits 3: Social Security Administration Notice and Department's testimony)

3. The Appellant is a recipient of Medicare A and B. A monthly premium of $104.90 is deducted from her Social Security benefit for Medicare. (Exhibit 3, Hearing Summary)

4. On [redacted] 2016, the Department received the Renewal Form from the Appellant. (Exhibit 11: Renewal form, Exhibit 9: Case narrative, Exhibit10: screen print of ConneCT Worker Portal Document Search)

5. The Appellant clearly stated on W-1ER that she is a recipient of Medicare A and Medicare B.( Exhibit 11)

6. On [redacted] 2016, the Department sent the Appellant a notice advising that it had denied QMB benefit for month of [redacted] 2016 and approved QMB benefit effective [redacted] of 2016. (Exhibit 2: Notice Content, [redacted]/16)

## 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 B 1 and 2 provides that an individual who qualifies for this coverage group may receive payment for Medicare Part A and B premiums and payment for coinsurance and deductible amounts for services covered under Medicare.

6. UPM § 2540.94 C provides for the duration of eligibility and states in part that an individual qualifies for benefits under this coverage group starting the first day of the calendar month following the month in which an individual is determined eligible.

7. UPM § 2540.94 provides the procedures to follow at intake and at each redetermination for all individuals receiving Medicaid, and for all individuals losing eligibility for cash benefits.

    1. Identify all individuals who might be eligible for Medicaid as QMB'S, including:
        a. individuals aged 65 and over; and
        b. individuals less than 65 years old who have been receiving SSA disability benefits for at least two years.
    2. Examine eligibility under the QMB coverage group, as described in 2540.94. Remember that income and assets must be within the appropriate limits. Refer to P 4530.20 p.2 and 4005.10 for the income and asset limits.
    3. If the individual is not eligible for Medicaid as a QMB, determine Medicaid eligibility under whatever other coverage group is appropriate.

8. The Appellant is a recipient of Medicare A and Medicare B.

9. The Department failed to identify the Appellant as an individual who might be eligible for QMB at the time of redetermination in [redacted] 2015.

10. The Department failed to acknowledge the receipt of W1-ER received by the Department on [redacted] 2016 until [redacted] 2016.

11. The Department was incorrect to grant QMB effective [redacted]/16.

## DISCUSSION

The Department received the Appellant's renewal form on [redacted] 2016 but failed to determine her eligibility for QMB until [redacted] 2016. The Policy is very clear that Department should identify all the individuals who might qualify for QMB at the time intake and redetermination. The Department's decision to grant QMB with an effective date of [redacted] 2016 is incorrect as it failed to explore the Appellant's eligibility for QMB in [redacted] of 2015.

## DECISION

The Appellant's appeal is **GRANTED**

## ORDER

1. The Department is directed to determine the Appellant's eligibility for QMB as of [redacted] 2015.

2. The Department will provide proof of compliance with this order no later than [redacted] 2016

Swati Sehgal
Swati Sehgal
Hearing Officer

CC: Poonam Sharma, Social Service Operations Manager, Bridgeport
Fred Presnick, Social Service Operations Manager, Bridgeport
Yecenia Acosta, Social Service Operations Manager, Bridgeport
Joseph Alexander, 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.