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

[redacted] 2017
Signature Confirmation

Client Id. # [redacted]
Hearing Id. # 798243

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2016, the Department of Social Services (the "Department") sent [redacted] (the "Appellant") a Notice of Action ("NOA") stating that he must meet a spenddown before his Medicaid can be activated.

On [redacted] 2016, the Appellant requested an administrative hearing to contest the Department's decision.

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, at the request of the Appellant, OLCRAH issued a notice rescheduling the administrative hearing for [redacted] 2017.

On [redacted] 2017, 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 participated in the hearing:

[redacted] the Appellant, via telephone
DeAsia Newman, Department's Representative
Carla Hardy, Hearing Officer

STATEMENTS OF THE ISSUE

The first issue is whether the Applicant's income exceeds the Medically Needy Income Limit ("MNIL") for Medicaid.

The second issue is whether the Applicant must meet a spenddown amount before being eligible for Medicaid.

FINDINGS OF FACT

1. The Appellant is a recipient of Social Security in the amount of $1,790.00 per month (Exhibit 4: Bendex Inquiry).

2. The Social Security benefit is the Appellant's only source of income (Appellant's Testimony).

3. The Appellant lives by himself (Appellant's Testimony).

4. The Appellant is a recipient of Medicare A and B. He was a recipient of the Medicare Savings Plan that paid the monthly Medicare B premium. He received a letter from the Department terminating this benefit effective [redacted] 2016 (Appellant's Testimony).

5. The Appellant incurs medical supply expenses totaling $75.00 per month that he has not submitted to the Department (Appellant's Testimony).

6. On [redacted] 2016, Xerox rejected medical bills from Home Care Plus totaling $5,170.32 that were submitted for the Appellant's spend-down. The bill was rejected because it was labeled an unacceptable verification of an expense (Exhibit 1: Case Narrative).

7. On [redacted] 2016, the Department sent the Appellant a notice advising him that his income exceeds the limit to receive medical assistance and that in order to be eligible for medical assistance; he must meet a spend-down of $5,182.32 for the period from [redacted] 2016 through [redacted] 2017 (Exhibit 3: Notice of Spend-down dated [redacted]/16).

CONCLUSIONS OF LAW

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

2. Uniform Policy Manual ("UPM") § 2540.01A provides that in order to qualify for medical assistance, an individual just meet the conditions of at least one coverage group.

3. UPM § 5500.01 provides that a needs group is the group of persons comprising the assistance unit and certain other persons whose basic needs are added to the total needs of the assistance unit members when determining the income eligibility of the assistance unit.

4. UPM § 5515.05 C 2 a and b provides in part that the needs group for an Medical Assistance for the Aged, Blind and Disabled ("MAABD") unit includes the applicant or recipient and the spouse of the applicant or recipient when they share the same home regardless of whether one or both applying for or receiving assistance, except in cases involving working individuals with disabilities.

5. UPM § 2015.05(A) provides that the assistance unit in Assistance to the Aged, Blind or Disabled ("AABD") and MAABD consists of only one member. In these programs, each individual is a separate assistance unit.

6. The Department correctly determined that the Appellant is in a needs group of one person and an assistance unit of one member.

7. UPM § 5050.13(A) (1) provides that income from Social Security is treated as unearned income for all programs.

8. UPM § 5050.13(A)(2) provides that Social Security income is subject to unearned income disregards in the Aid to the Aged, Blind, and Disabled ("AABD") and Medicaid for the Aid to the Aged, Blind, and Disabled ("MAABD") programs.

9. UPM § 5030.15(A) provides that except as provided in section 5030.15 D., unearned income disregards are subtracted from the unit member's total gross monthly unearned income.

10. UPM § 5030.15(B)(1)(a) provides that the standard disregard is $227.00 for those individuals who reside in their own homes in the community or who live as roomers in the homes of others and those who reside in long term care facilities, shelters for the homeless or battered women shelters. Effective January 1, 2008, and each January 1st thereafter, this disregard shall be increased to reflect the annual cost of living adjustment used by the Social Security Administration. The current disregard is $337.00.

11. UPM § 5030.15(B)(1)(c) provides that the special disregard is $294.90 for those individuals who share non-rated housing with at least one person who is not related to them as parent, spouse or child. This does not apply to

individuals who reside in shelters for battered women or shelters for the homeless. Effective January 1, 2008, and each January 1st thereafter, this disregard shall be increased to reflect the annual cost of living adjustment used by the Social Security Administration. The current disregard is $404.90.

12. The Appellant resides alone and is eligible for the $337.00 standard disregard.

13. UPM § 5045.10(C)(1) provides that except for determining AABD eligibility and benefit amounts for individuals residing in long term care facilities, applied unearned income is calculated by reducing the gross unearned income amount by the appropriate disregard based upon living arrangements.

14. The Department incorrectly determined that the Appellant's applied income equals $1,395.10 ($1,790.00-$404.90) per month.

15. The Appellant's correct applied income equals $1,453.00 ($1,790.00-$337.00).

16. UPM § 5045.10(E) provides that the assistance unit's total applied income is the sum of the units applied earnings, applied unearned income and the amount deemed.

17. The Department incorrectly calculated the Appellant's total applied income at $1,395.10.

18. The correct total applied income equals ($0.00 applied earnings + $1,453.00 applied unearned income + 0.00 deemed income).

19. UPM § 5520.20(B)(1) provides that a six month period for which eligibility will be determined is established to include the month of application and the five consecutive calendar months which follow.

20. The Department correctly calculated the Appellant's six month period of eligibility as October 2016 through March 2017.

21. UPM § 4530.15(A) pertains to the medical assistance standards. It provides that a uniform set of income standards is established for all assistance units who do not qualify as categorically needy. It further states that the Medically Needy Income Limit ("MNIL") of an assistance unit varies according to the size of the assistance unit and the region of the state in which the assistance unit resides.

22. UPM § 4530.15(B) provides that the MNIL is the amount equivalent to 143 percent of the benefit amount that ordinarily would be paid under the AFDC

program to an assistance unit of the same size with no income for the appropriate region of residence.

23. UPM § 4510.10(B) provides that [redacted] is part of Region B.

24. The Department correctly determined that the Appellant resides in Region B.

25. The Temporary Family Assistance grant for one person residing in Region B is $366.00.

26. The MNIL for one person residing in region B is $523.38 ($366.00 X 143%).

27. The Department correctly determined that the MNIL for a needs group of one is $523.38.

28. UPM § 5520.25(B) provides that when the amount of the assistance unit's monthly income exceeds the MNIL, income eligibility for the medically needy assistance unit does not occur until the amount of excess income is offset by medical expenses. This process of offsetting is referred to as a spend-down.

29. The Department incorrectly determined that the Appellant's applied income exceeds the MNIL by $861.72.

30. The Appellant's applied income exceeds the MNIL by $929.62 ($1,790.00 social security- $337.00 disregard - $523.38 MNIL)

31. The Department incorrectly determined that during the six month period from [redacted] 2016 to [redacted] 2017, the Appellant's applied income exceeded the MNIL by $5,170.32.

32. The Appellant's applied income for the period [redacted] 2016 to [redacted] 2017 exceeds the MNIL by $5,577.72 ($929.62 x 6).

33. UPM § 5520.25(B) provides for the use of medical expenses under a spend-down.

    1. Medical expenses are used for a spend-down if they meet the following conditions:
        a. the expenses must be incurred by a person whose income is used to determine eligibility;
        b. any portion of an expense used for a spend-down must not be payable through third party coverage unless the third party is a public assistance program totally financed by the State of Connecticut or by a political subdivision of the State;

c. there must be current liability for the incurred expenses, either directly to the provider(s) or to a lender for a loan used to pay the provider(s), on the part of the needs group members;
d. the expenses may not have been used for a previous spend-down in which their use resulted in eligibility for the assistance unit.

2. The unpaid principal balance which occurs or exists during the spend-down period for loans used to pay for medical expense incurred before or during the spend-down period, is used provided that:
   a. the loan proceeds were actually paid to the provider; and
   b. the provider charges that were paid with the loan proceeds have not been applied against the spend-down liability; and
   c. the unpaid principal balance was not previously applied against spend-down liability, resulting in eligibility being achieved.
3. Medicaid expenses are used in the following order of categories and, within each category, chronologically starting with the oldest bills:
   a. first, Medicare and other health insurance premiums, deductibles, or coinsurance charges. Medical insurance premium expenses which exist at the time of the processing of the application which are reasonably anticipated to exist for six month prospective period are considered as a six-month projected total;
   b. then, expenses incurred for necessary medical and remedial services that are recognized under State Law as medical costs but <u>not</u> covered by Medicaid in Connecticut.
4. When unpaid loan principal balances are used, they are categorized by the type of expense they were used to pay, as in B.3.
5. Expenses used to determine eligibility in a retroactive period are used in the following order:
   a. <u>unpaid</u> expenses incurred anytime prior to the three-month retroactive period; then
   b. <u>paid or unpaid</u> expenses incurred within the three-month retroactive period but not later than the end of the retroactive month being considered; then
   c. an unpaid principal balance of a loan which exists during the retroactive period.
6. Expenses used to determine eligibility in the prospective period are used in the categorical and chronological order described previously.
7. Income eligibility for the assistance unit exists as of the day when excess Income is totally offset by medical expenses: Any portion of medical expenses used to offset the excess income are the responsibility of the unit to pay.
   a. Medical expenses which are recognized as payable under the State's plan and which are remained unpaid at the time eligibility begins are paid by the Department provided the expenses were not used to offset income.

34. UPM § 5520.30(B)(3) provides that when the amount of incurred expense is insufficient to offset the excess income, no eligibility exists for that six month period.

35. The Department correctly determined that the Appellant must meet a spend-down in order to become eligible for MAABD.

DISCUSSION

The Department incorrectly gave the Appellant the special disregard when he was eligible for the standard. This caused the spend-down to be understated. The Appellant has one medical bill from Home Care Plus which was rejected for the spend-down for reasons unknown. It was suggested that he resubmit that bill in an itemized format along with his bill for medical supplies that he has yet to submit.

In addition, the Appellant's Medicare Savings Plan was terminated effective [redacted] 2016. If he remains ineligible for this program, the Medicare B premiums should also be applied toward the spend-down. The Department correctly determined that the Appellant must meet a spend-down in order to become eligible for MAABD.

DECISION

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

Carla Hardy
Carla Hardy
Hearing Officer

Pc: Lisa Wells, Operations Manager, New Haven
Cheryl Stuart, Program Manager, New Haven
Brian Sexton, Operations Manager, New Haven
DeAsia Newman, Fair Hearing Liaison, New Haven

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.