

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

██████████ 2017  
Signature Confirmation

Request # 803592  
Client ID # ██████████

NOTICE OF DECISION

PARTY

██████████  
C/o ██████████  
██████████  
██████████  
██████████

PROCEDURAL BACKGROUND

On ██████████ 2016, the Department of Social Services (the “Department”) sent ██████████ (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 ██████████ 2016, the Appellant, by his authorized representative, requested an administrative hearing to appeal the Department’s decision to discontinue his Medicaid benefits.

On ██████████ 2016, the Office of Legal Counsel, Regulations, and Administrative Hearings (“OLCRAH”) issued a notice scheduling the administrative hearing for ██████████ 2017.

On ██████████ 2017, the Appellant requested his administrative hearing be rescheduled.

On ██████████ 2017, OLCRAH issued a notice rescheduling the administrative hearing for ██████████ 2017.

On ██████████ 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 were present at the hearing:

██████████ the Appellant  
 ██████████ Appellant's authorized representative  
 Kenneth Smiley, Department's Representative  
 Scott Zuckerman, Hearing Officer

The hearing record was held open for the Appellant's authorized representative to submit additional evidence. On ██████████ 2017, 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 ██████████ 2016 due to outstanding unpaid premiums.

### **FINDINGS OF FACT**

1. On ██████████ 2016, the Department sent the Appellant a notice granting Medicaid for the Employed Disabled benefits effective ██████████ 2015. (Hearing Summary, Exhibit 3: Notice dated ██████████ 2016)
2. The ██████████ 2016 notice informed the Appellant of premium amounts. Between ██████████ 2015 and ██████████ 2016, the Appellant's premiums for the program were assessed as follows: ██████████ 2015 - \$75.25, ██████████ 2015 - \$75.25, ██████████ 2016 - \$75.25 and ██████████ 2016 \$44.55: premiums totaled \$225.75 with a due date of ██████████ 2016. The notice stated beginning in ██████████ 2016 the premium will be \$44.55 billed monthly. (Ex. 3)
3. On ██████████ 2016, the Department sent the Appellant a Notice of Discontinuance. The notice stated, "you did not make your premium payment by the due date. You will be ineligible until any past due is paid in full." (Exhibit 4, Notice dated ██████████/16)
4. On ██████████ 2016, the Department received a premium payment of \$45.00. (Exhibit 5: Benefit History Receipts)
5. On ██████████ 2016, the Appellant applied for medical assistance. (Ex. 6: W-1ER, Renewal of Eligibility form, ██████████ 16)
6. On ██████████ 2016, the Appellant was granted Medicaid for the Employed disabled effective ██████████ 2016. The Appellant was informed of premium of amounts between ██████████ 2016 through ██████████ 2016 as follows: ██████████

2016: \$26.01, █████ 2016 - \$13.97, █████ 2016- \$13.97. The premium for █████ 2016 and ongoing - \$40.79. The letter indicated the Total premium due for █████ 2016 through █████ 2016 was \$53.95 due by █████ 2016. (Exhibit 7: Case narrative █████/16 and Notice of Eligibility and Premium Obligation, █████/16)

7. On █████ 2016, the Department received a premium payment in the amount of \$53.00. (Exhibit 9 : Benefit History Receipts)
8. The Department did not receive the █████ 2016 payment of \$40.79. (Hearing Record)
9. On █████ 2016, the Department sent the Appellant a Notice of Discontinuance effective █████ 2016. The notice stated, “you did not make your premium payment by the due date. You will be ineligible until any past due is paid in full.” (Exhibit 10: Notice dated █████ 2016)
10. On █████ 2016, the Appellant applied for medical assistance. (Exhibit 11: Case narrative █████/16)
11. On █████ 2016, the Appellant was granted Medicaid for the Employed disabled effective █████ 2016. The Appellant was sent a notice of Eligibility and Premium Obligation. The Premium was assessed at \$61.81 and payment was due by █████ 2016. (Exhibit 11: Case narrative █████/16 and Exhibit 12: Notice dated █████ 16)
12. On █████ 2016, the Department sent the Appellant a Notice of Premium change. The notice stated that the Premium amount effective █████ 2016 will be \$37.84. (Exhibit 15: Notice dated █████/16)
13. On █████ 2016, the Department received payment of \$62.00. (Exhibit 13: Benefit History Receipts)
14. On █████ 2016, the Department sent the Appellant a Notice of Discontinuance. The notice stated the Appellant’s Medical assistance will be discontinued effective █████ 2016 for reason, “you did not make your premium payment by the due date. You will be ineligible until any past due is paid in full.” (Exhibit 18: Notice dated █████ 2016)
15. The Appellant’s monthly premium charges and payments are as follows:

Benefit Month	Premium Amount	Payment Date/ Amount	Due Date
█████ 2015	\$75.25		█████ 2016

██████████ 2015	\$75.25		██████████ 2016
██████████ 2016	\$75.25		██████████ 2016
██████████ 2016	\$44.55	██████████ 2016 \$45.00	██████████ 2016
██████████ 2016	\$26.01		██████████ 2016
██████████ 2016	\$13.97		██████████ 2016
██████████ 2016	\$13.97	██████████ 2016 \$53.00 (3/16 – 5/16)	██████████ 2016
██████████ 2016	\$40.79		██████████ 2016
██████████ 2016	\$61.81	Paid ██████████ 2016 \$62.00	██████████ 2016
██████████ 2016	\$37.84		██████████

(Hearing Record)

16. The Appellant has premiums in arrears for ██████████ 2015 (\$75.25), ██████████ 2015 (\$75.25), ██████████ 2016 (\$75.25) and ██████████ 2016 (\$40.79). ( Ex. 3, Ex. 9, Ex. 10)

17. The Appellant owes \$37.84 ongoing premium for ██████████ 2016. ( Ex. 15)

### **CONCLUSIONS OF LAW**

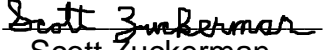
1. Section 17b-2 and § 17b-260 of the Connecticut General Statutes, authorizes the Department of Social Services to administer the Medicaid program pursuant to Title XIX of the Social Security Act.
2. Uniform Policy Manual (“UPM”) § 2540.85 provides for the eligibility requirements for Medicaid for Working 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 ██████████ 2016 because the required premium payments for the program were in arrears.

**DECISION**

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

  
Scott Zuckerman  
Hearing Officer

cc: Tonya Cook-Beckford, Operations Manager, DSS, Willimantic R.O.  
Kenneth Smiley, Fair Hearing Liaison, DSS, Willimantic R.O.

### **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.