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]
Request # 829428

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2017, the Department of Social Services (the "Department") sent [redacted] (the "Appellant") a Notice of Action ("NOA) advising her that she must meet a spend-down before her Medical Assistance for the Ages, Blind and Disables ("MAABD") can be activated.

On [redacted] 2017, the Appellant requested an administrative hearing to contest the Department's action.

On [redacted] 2017, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a Notice scheduling the administrative hearing for [redacted] 2017.

On [redacted] 2017, 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:

[redacted] Appellant
Vivian Echevarria, Fair Hearing Liaison, New Britain Regional Office
Almelinda McLeod, Hearing Officer

STATEMENT OF THE ISSUE

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

The second issue to be determined is whether the Appellant must meet a spend-down amount before being eligible for Medicaid.

FINDINGS OF FACT

1. The Appellant is a household of one residing in [redacted], CT who meets the disability requirement to qualify for the Medicaid for Ages, Blind and Disables program. (Exhibit 2)

2. The Appellant's only income source comes from Social Security disability. Her gross income is $945.00 per month. (Hearing summary and Exhibit 3)

3. The Department allowed for the unearned income disregard of $339.00 from the Appellant's Social Security disability income. (Hearing summary)

4. The Department determined that the Appellant's Net Unearned income was $606.00. [$945.00 -$339]. (Hearing summary and Exhibit 4)

5. The Appellant is active on the Qualified Medicare Beneficiaries (QMB). (Hearing record)

6. On [redacted] 2017, the Department issued a NOA to the Appellant informing her that her income was too high to receive medical assistance for the certification period [redacted] 2017 to [redacted] 2017, and that she must have medical bills that she owes or has recently paid totaling $495.72 before her eligibility for medical assistance can begin. (Exhibit 1 and Exhibit 4)

7. The Appellant submitted a medical expense she incurred in [redacted] 2017 along with her renewal form. (Appellant's testimony)

8. The Department denied the medical bill because Medicare had not been bill first. (Exhibit 7)

9. The Appellant does not agree with the spend-down amount and in fact disagrees that she should even be on a spend-down at all. The Appellant testified that by the time she has met the spend-down amount needed to activate her Medicaid, the spend-down period is over and she has to start all over again. In addition, the spend-down amount is too much for her. (Appellant testimony)

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") § 5515.05(C) (2) provides in part that the needs group for an MAABD (Medical Assistance for the Aged, Blind and Disabled) 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 are applying for or receiving assistance, except in cases involving working individuals with disabilities.

   The Department was correct when it determined that the Appellant is an MAABD needs group of one person.

3. UPM § 4530.15 (A) 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.

4. UPM § 4510.10 (A) (3) provides that the standard of need which is applicable to a particular assistance unit is based on: a. the current region of residence; and b. the appropriate needs group size.

5. UPM § 2540.01 (C) provides that individuals qualify for medical assistance ("MA") as medically needy if: 1. their income or assets exceed the limits of the Aid to Families with Dependent Children ("AFDC") or Aid to the Aged, Blind and Disabled ("AABD") programs; and 2. their assets are within the medically needy asset limit; and 3. their income either:

   a. is within the Medically Needy Income Limit ("MNIL"); or
   b. can be reduced to the MNIL by a spend-down of medical expenses

6. UPM § 4530.15(B) provides that the medically needy income limit 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.

7. UPM § 4510.10(A) provides that 1. The State of Connecticut is divided into three geographic regions on the basis of a similarity in the cost of housing. 2. Separate standards of need are established for each state region. 3. The standard of need which is applicable to a particular assistance unit is based on:

a. a. the current region of residence; and
b. b. the appropriate needs group size.

8. UPM § 4510.10(B) provides a regional breakdown of cities and towns in the state, and provides that the Appellant's city of residence, New Britain, is part of Region B.

   The Temporary Family Assistance Payment Standard for a household of one person with no income in Region B is $366.00

   The MNIL for a needs group of one person residing in Region B is $523.38 ($366.00 x 143%)

9. UPM § 5050.13 (A) (1) provides that Social Security benefits are treated as unearned income for all programs.

   The Department was correct when it determined that the Appellant's income consists of $945.00 Social Security per month and treated as unearned income.

10. 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

11. 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.

12. UPM § 5030.15(B) (1) (a) provides that the 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.

    After annual adjustments for cost of living increases, the unearned income disregard for one person is $339.00 effective [redacted] 2017.

    The Appellant's applied income, after deducting the unearned income disregard from his Social Security income, is $606.00 ($945.00, minus $339.00).

13. 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.

14. UPM § 5520.20(B)(5) provides that the total of the assistance unit's applied -income for the six-month period is compared to the total of the MNIL's for the same six-months.

15. UPM § 5520.20(B)(5)(b) provides that when the unit's total applied income is greater than the total MNIL, the assistance unit is ineligible until the excess income is offset through the spend-down process.

16. UPM § 5520.25(B) provides that when the amount of the assistance unit's monthly income exceeds the MNIL, income eligibility for a 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.

17. **The Department was correct when it determined that the Appellant's applied income exceeds the MNIL by $82.62 in each month ($606.00 applied income, minus $523.38 MNIL)**

18. **The Department was correct when it determined that, during the six-month period from [redacted] 2017 to [redacted] 2017, the Appellant's applied income exceeds the MNIL by $495.72. ($82.62 monthly excess x six months)**

19. **The Department was correct when it determined that the Appellant is ineligible until the excess income during the six-month period from [redacted] 2017 to [redacted] 2017 is offset by medical bills through the spend-down process.**

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

    (1) provides that 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 determined 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 not 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. unpaid expenses incurred any time prior to the three-month retroactive period; then
b. paid or unpaid 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.

21. The Appellant submitted a medical bill from [redacted] Hospital in [redacted] along with her renewal; however Medicare had not been billed first.

22. The Department correctly rejected the medical bill because the State Medicaid is secondary insurance and Medicare must be billed first.

23. 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.

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

DISCUSSION

Based on the testimony and evidence provided, the Appellant's applied income exceeded the MNIL and thus must meet the spend- down amount of $495.72 before she can be activated. I find no error in the Department's calculation of the Appellant's spend-down for the certification period of [redacted] 2017 to [redacted] 2017.

The Appellant incurred a medical expense in [redacted] 2017 and had submitted that bill to the Department along with her renewal, however, the Department found that Medicare had not been billed as the primary insurer and thus rejected the bill. The Appellant is encouraged to follow up with the Department regarding that bill.

DECISION

The Appellant's appeal is DENIED

Almelinda McLeod
Hearing Officer

CC: Phil Ober, SSOM, New Britain Regional Office
Patricia Ostroski, SSPM, New Britain Regional Office
Vivian Echevarria, Fair Hearing Liaison, New Britain Regional Office

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 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, 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 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.