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

[redacted] **2019**
Signature Confirmation

Client ID # [redacted]
Request # [redacted]

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2018, the Department of Social Services (the "Department") sent [redacted] (the "Appellant") a Notice of Action ("NOA) denying benefits under the Qualified Medicare Beneficiaries ("QMB") benefits for failure to provide information.

On [redacted] 2018, the Appellant requested an administrative hearing to contest the Department's decision to deny/discontinue/reduce such benefits.

On [redacted] 2018, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a Notice scheduling the administrative hearing for [redacted], 2018.

On [redacted], 2019, the Appellant requested a continuance of the hearing, which was granted.

On [redacted], 2019, OLCRAH issued a Notice scheduling the administrative hearing for [redacted].

On [redacted] 2019, 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
[redacted], Appellant's spouse
Elena Toletti, Department Representative
Claudia Ale, ITI Spanish Interpreter
Almelinda McLeod, Hearing Officer

The hearing record was held open for the submission of additional evidence. On [redacted] 2019 the hearing record was closed.

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department's decision to discontinue the Medicare Savings Program ("MSP") under the Qualified Medicare Beneficiaries ("QMB"), Q01Program was correct.

FINDINGS OF FACT

1. On [redacted], 2018, the Appellant applied for Husky C Medicaid. (Hearing Summary)

2. The Appellant is married residing with his spouse; this is a household of two. (Hearing summary)

3. Prior to the Husky C Medicaid application, the Appellant was active on the Qualified Medicare Beneficiaries ("QMB") Q01 program. (Hearing summary)

4. The Appellant works part-time for Wal-Mart where he works an average of 22 to 27 hours week and is paid bi-weekly. (Appellant's testimony)

5. The Appellant's spouse works for A & B homecare where she works an average of 35 to 37 hours per week. (Appellant's testimony)

6. The Department verified the Appellants Wal-Mart wages through the Work Number Verifier. (Department's testimony)

7. The Appellant and his spouse were both sponsored by the Appellant's son who resides in [redacted] approximately 10 to 11 years ago. (Appellant's testimony)

8. On [redacted] 2019, the Department issued a W-1348- Proofs We Need form requesting sponsorship information, motor vehicle information, most recent Bank statement and the 4 most recent weekly paystubs for the

Appellant's spouse for both the Husky C Medicaid and the QMB program. The due date for this information was [redacted], 2018. (Exhibit 2- W-1348 Proofs We Need form)

9. The Appellant provided all of the information with the exception of the sponsorship information to a social worker with the Meriden senior center; through which their application was made. (Appellant's testimony)

10. The Department did not receive any of the requested documentation prior to the due date of [redacted], 2018 in order to determine eligibility for medical assistance. (Department testimony)

11. The Department conducted a subsequent search in the Department's IMPACT system and found that none of the requested documents were submitted. (Exhibit 6, IMPACT Document Search)

12. On [redacted], 2018, the Department issued a Notice of Action ("NOA") discontinuing the MSP under the QMB program effective [redacted] because "you did not return all of the required proofs by the date we asked. Does not meet program requirements." (Exhibit 3, NOA)

13. The issuance of this decision is timely under section 17b-61 (a) of the General Statutes, which requires that a decision be issued within 90 days of the request for an administrative hearing. The Appellant requested an administrative hearing on [redacted] 2018. This decision, therefore was due no later than [redacted] 2019. However, the Appellant requested to reschedule the administrative hearing which extended the close of the hearing record. Because of this 39 day delay, the final decision was not due until [redacted] 2019, and is therefore timely.

CONCLUSIONS OF LAW

1. Section 17b-2 and § 17b-260 of the Connecticut General Statutes, authorizes Commissioner of the Department of Social Services to administer the Medicaid program pursuant to Title XIX of the Social Security Act.

2. Federal Statutes provides 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 13951-2 of this title.) [42 United States Code ("USC") § 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 (CGS") provides for the Medicare Saving Program Regulations. 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) provides for Qualified Medicare Beneficiaries ("QMB") coverage group to include individuals who: a. are entitled to hospital insurance benefits under part A of Title XVIII of the Social Security act; and b. have income and assets equal to or less than the limits described in paragraph C and D.

5. UPM 1505.40 (A) provides that prior to making an eligibility determination; the Department conducts a thorough investigation of all circumstances relating to eligibility and the amount of benefits.

6. UPM § 1540.05(C) (1) provides that the Department requires verification of information (a) when specifically required by federal or State law or regulations; and (b) when the Department considers it necessary to corroborate an assistance unit's statements pertaining to an essential factor of eligibility.

7. UPM § 1015.10 (A) provides that the Department must inform the assistance unit regarding the eligibility requirements of the programs administered by the Department and regarding the unit's rights and responsibilities.

8. UPM 1015.05 (C) provides that the Department must inform the assistance unit what the unit has to do to establish eligibility when the Department does not have sufficient information to make an eligibility determination.

9. The Department correctly notified the Appellant that required documents were needed in order to establish eligibility and properly requested such information by issuing a W-1348, Proofs We Need form.

10. UPM 1505.40 (A) provides that prior to making an eligibility determination; the Department conducts a thorough investigation of all circumstances relating to eligibility and the amount of benefits.

11. UPM § 1010.05(A)(1) provides that the assistance unit must supply the Department in an accurate and timely manner as defined by the Department, all pertinent information and verification which the Department requires to determine eligibility and calculate the amount of benefits.

12. UPM 1540.10 (A) .pertains to the general principles of Verification during the eligibility process with respect to the Unit and Agency responsibilities and provides in part; the assistance unit bears the primary responsibility for providing evidence to corroborate its declarations.

13. UPM 1540.05 (D) (1) (a) (b) pertains to consequences for Failure to Provide Verification. The penalty for failure to provide required verification depends upon the nature of the factor or circumstances for which verification is required: If the eligibility of the assistance unit depends directly upon a factor or circumstances for which verification is required, failure to provide verification results in ineligibility for the assistance unit. Factors on which unit eligibility depends directly include, but are not limited to are income amounts and asset amounts.

14. As income is a determining factor when determining eligibility for the QMB program, the Department correctly determined that verification of income from the Appellant, his spouse and the Appellant's sponsor was a required verification.

15. **The Department correctly discontinued the QMB, Q01 Medicaid benefits for failing to provide requested verifications by the due date.**

DISCUSSION

After reviewing the testimony and the evidence presented, the Department was correct to deny the appellant's application for QMB medical assistance. The requested documentations were not provided to the Department by the due date, [redacted] 2018; thus the application was denied because the necessary information was not provided.

The Appellant testified that all documents with the exception of sponsorship information had been provided through a social worker from a local senior center; however there is no evidence that the Department ever received any such documents on behalf of the Appellant. The Department is upheld.

The appellant may reapply with the Department at any time and provide the requested information for ongoing eligibility.

DECISION

The Appellant's appeal is DENIED

Almelinda McLeod
Hearing Officer

CC: Brian Sexton, SSOM, Middletown Regional Office
Eleana Toletti, Fair Hearing Liaison, Middletown 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.