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

[redacted] 2022
Signature Confirmation

Client ID [redacted]
Case ID [redacted]
Request # 184938

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted], 2021, the Department of Social Services (the "Department") sent [redacted] (the "Appellant") a Notice of Action ("NOA) renewing her Medicaid benefits under the Medically Needy for Aged, Blind, and Disabled Program ("MAABD") under a spenddown effective [redacted]1, 2021.

On [redacted] 2021, the Appellant requested an administrative hearing to contest the Department's calculation of her spenddown amount.

On [redacted], 2021, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2021.

On [redacted] 2021, the Appellant requested a continuance which OLCRAH approved.

On [redacted], 2021, the OLCRAH issued a notice scheduling the administrative hearing for [redacted], 2022.

On [redacted], 2022, 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], Witness for the Appellant
Garfield White, Department's Representative
Yajaira Joaquin-Ortiz, Interpreter, Interpreters and Translators, Inc.
Lisa Nyren, Hearing Officer

The record remained open for the submission of additional evidence. On [redacted], 2022, the record closed.

STATEMENT OF THE ISSUE

The primary issue to be decided is whether the Appellant must meet a spenddown under the Husky C – Medically Needy Aged, Blind, Disabled – Spenddown program ("MAABD spenddown program") before medical coverage under Medicaid is activated.

A secondary issue is whether the Department calculated the Appellant's MAABD spenddown amount as $726.00 for the six month spenddown period [redacted] 2021 through [redacted], 2022 correctly.

FINDINGS OF FACT

1. The Appellant receives medical coverage under the MAABD spenddown program as administered by the Department. (Hearing Record)

2. The Appellant is age [redacted] (Appellant's Testimony)

3. The Appellant is not married. (Appellant's Testimony)

4. The Appellant is disabled. (Appellant's Testimony)

5. The Appellant lives in [redacted]. (Appellant's Testimony)

6. The Appellant shares her apartment with [redacted] ("Witness"). The Witness is the father of the Appellant's two children. (Appellant's Testimony and Witness' Testimony)

7. In 2021, the Appellant received Social Security Disability ("SSDI") benefits of $1,015.00 per month. (Stipulated)

8. Beginning 2022, the Appellant's SSDI increased to $1,074.00 per month. (Appellant's Testimony)

9. The Appellant receives Medicare Part A, Medicare Part B, and Medicare Part D benefits from the Social Security Administration. (Appellant's Testimony)

10. The Appellant receives Medicaid under the Medicare Savings Plan ("MSP") Qualified Medicare Beneficiary ("QMB") program. The QMB program pays the Appellant's Medicare Part B premiums monthly and the co-pays and deductibles for Medicare covered services. (Department Representative's Testimony)

11. The medically needy income limit ("MNIL") under the MAABD program is $532.00. (Department Representative's Testimony)

12. The Department determined the Appellant's total countable income as $653.00 per month. $1,015.00 SSDI - $362.00 standard unearned income disregard = $653.00. (Department Representative's Testimony)

13. The Department determined the Appellant's countable income of $653.00 exceeds the Husky MNIL of $532.00 resulting in eligibility for medical coverage under the MAABD spenddown program with a spenddown amount of $726.00 for the 6-month spenddown period [redacted] 2021 through [redacted], 2022. $653.00 applied income - $532.00 MNIL = $121.00 excess income x 6 months = $726.00 spenddown amount. (Hearing Record)

14. On [redacted], 2021, the Department notified the Appellant that her income is too high for "ACTIVE medical coverage which means the individual(s) is still in a spend-down." The notice lists the spend-down amount as $726.00 for the spend-down period [redacted] 2021 through [redacted] 2022. "Medical coverage for the individual(s) will become active (no longer in a spend-down) when the individual(s) shows DSS proof of acceptable medical expenses, not covered by Medicare or other insurance, for the total amount of the spend-down." (Exhibit 2: Notice of Action)

15. The Appellant has out of pocket medical expenses. The Appellant pays co-pays for her prescription medication which averages $125.00 to $150.00 per month. Proof of out of pocket prescription co-pays was not provided to the Department. (Appellant's Testimony and Witness Testimony)

16. On [redacted] 2021, the Appellant submitted the following documents with her hearing request:

[redacted]., a debt collection agency, statement listing total due as $440.70 listing the creditor as [redacted].

[redacted] statement listing total due as $41.71.

[redacted] statement, service dates [redacted]/19 $17.00 and [redacted]/20 – [redacted]/20 $12.85

[redacted]: [redacted]/19 office outpatient services $9.91, [redacted]/19 office outpatient services $17.00. [redacted]/20 physical therapy $12.85, Total due $39.76

Delivery Ticket for DME [redacted] Walker with wheels (the "replacement walker"), [redacted]/21.

(Exhibit A: Hearing Request Medical Documents)

17. The Appellant's son paid for the replacement walker on behalf of the Appellant. Medicare limits payments for a walker to one every five years and because the Appellant received a walker within 5-years of the replacement walker, Medicare declined coverage for the replacement walker. (Appellant's Testimony and Witness' Testimony)

18. The Appellant has not submitted proof of out of pocket medical expenses to the Department prior to her request for an administrative hearing. (Appellant's Testimony)

19. The issuance of this decision is timely under Connecticut General Statutes § 17b-61(a), 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] 2021. However, the hearing, which was originally scheduled for [redacted] 2021, was rescheduled at the request of the Appellant, which caused a [redacted]-day delay. However, the close of the hearing record, which was scheduled to close on [redacted] 2022, did not close until [redacted] 2022 to allow the Appellant additional time to submit evidence. Because this [redacted]-day delay resulted from the Appellant's request, this decision is not due until [redacted] 2021, and therefore timely.

CONCLUSIONS OF LAW

1. Section 17b-2(6) of the Connecticut General Statutes provides as follows: The Department of Social Services is designated as the state agency for the administration of the Medicaid program pursuant to Title XIX of the Social Security Act.

2. "The department's uniform policy manual is the equivalent of a state regulation and, as such, carries the force of law." *Bucchere v. Rowe,* 43 Conn. Supp. 175, 178 (1994) (citing Conn. Gen. Stat, § 17b-10; *Richard v. Commissioner of Income Maintenance,* 214 Conn. 601, 573 A.2d 712(1990))

3. Section 2530 of the Uniform Policy Manual ("UPM") provides as follows:

   Certain individuals applying for AABD or Medical Assistance must be disabled to qualify for assistance. The Social Security Administration (SSA) generally is responsible for determining if an individual is disabled. Under certain conditions, the Department makes a determination separate from SSA. The Department uses the same criteria as SSA to determine disability. In most cases, a decision by SSA takes precedence over a decision which has been made by the Department's Medical Review Team (MRT). This chapter discusses the controlling nature of the SSA decision and the circumstances under which the Department makes a determination apart from SSA.

   Department policy provides as follows:

   To qualify for the State Supplement or related Medical Assistance programs on the basis of disability, the individual must be disabled as determined by SSA or the Department.

   1. Is medically determinable; and
   2. Is severe in nature; and
   3. Can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months; and
   4. Except as provided in paragraph C below, prevents the performance of previous work or any other substantial gainful activity which exists in the national economy.

   UPM § 2530.05(A)

   "An individual who is considered disabled by SSA is considered disabled by the Department." UPM § 2530.10(A)

   The Department correctly determined the Appellant meets the disability requirement under the MAABD program because the Social Security Administration determined her as disabled.

4. Department policy provides as follows:

Medically Needy Aged, Blind and Disabled. Coverage Group Description. This group includes individuals who:

1. Meet the MAABD categorical eligibility requirements of age, blindness or disability; and
2. Are not eligible as categorically needy; and
3. Meet the medically needy income and asset criteria.

UPM § 2540.96(A)

Department policy provides as follows:

The Department uses the MAABD medically needy income and asset criteria to determine eligibility under this coverage group, including:

1. Medically needy deeming rules;
2. The Medically Needy Income Limit ("MNIL");
3. The income spend-down process;
4. The medically needy asset limits.

UPM § 2540.96(C)

5. "A uniform set of income standards is established for all assistance units who do not qualify as categorically needy." UPM § 4530.15(A)(1)

   Department policy provides as follows: The MNIL of an assistance unit varies according to:

   a. the size of the assistance unit; and
   b. the region of the state in which the assistance unit resides.

   UPM § 4530.15(A)(2)

   "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." UPM § 4530.15(B)

   "The regional breakdown of the state by cities and towns is as follows: Region B West Hartford." UPM § 4510.10(B)(2)

   The Department correctly determined that the MNIL for the Appellant's assistance unit for one person as $532.00 in Region B. The Department correctly determined [redacted] as Region B.

6. "Income from these sources [Social Security] is treated as unearned income in all programs." UPM § 5050.13(A)(1)

   "If income is received on a monthly basis, a representative monthly amount is used as the estimate of income." UPM § 5025.05(B)(1)

   The Department correctly determined the Appellant's SSA benefit as $1,015.00 per month.

   The Department correctly determined the Appellant's monthly gross unearned income as $1,015.00.

7. "This income [Social Security] is subject to an unearned income disregard in the AABD and MAABD programs. UPM § 5050.13(A)(2)

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

   "All of the disregards used in the AABD programs are used to determine eligibility for MAABD." UPM § 5030.15(C)(2)(a)

   "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." UPM § 5045.10(C)(1)

   Department policy provides as follows:

   The Department uses the following unearned income disregards, as appropriate under the circumstances described: The disregard is [$429.90] 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.

   UPM § 5030.15(B)(1)(c)

   The Department incorrectly determined the Appellant's unearned income disregard as the standard disregard of $362.00. The Appellant qualifies for the special disregard of $429.90 because she resides with the Witness who is not related to her as a parent,

spouse, or child. Although the Witness is the father of her children, she is not married to the Witness.

The Department incorrectly calculated the Appellant's applied unearned income as $653.00. The correct applied unearned income is $585.10. ($1,015.00 SSDI - $429.90 special disregard = $585.10)

8. "The assistance unit's total applied income is the sum of the unit's applied earnings, applied unearned income, and the amount deemed." UPM § 5045.10(E)

   The Department incorrectly calculated the Appellant's total applied income as $653.00. The correct applied income is $585.10. ($00.00 applied earned income + $585.10 applied unearned income + $00.00 deemed income = $585.10 total applied income)

9. Department policy provides as follows:

   An MNIL is determined for each of six months is determined on the basis of:

   a. The anticipated place of residency of the assistance unit in each of the six months; and
   b. The anticipated composition of the needs group for each of the same six months.

   UPM § 5520.20(B)(3)

   Department policy provides as follows:

   The needs group for an MAABD unit includes the following:

   a. The applicant or recipient; and
   b. 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. In these cases, the spouse (and children) are part of the needs group only in determining the cost of the individual's premium for medical coverage (Cross Reference: 2540.85).

   UPM § 5515.05(C)(2)

   "The income limit used to determine Medicaid eligibility is the limit for the number of persons in the needs group." UPM § 5515.10(C)

"The assistance unit's applied income is estimated for each of the six months." UPM § 5520.20(B)(4)

Department policy provides as follows:

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:

a. When the unit's total applied income equals or is less than the total MNIL's the assistance unit is eligible;
b. When the unit's total applied income, is greater than the total MNIL's the assistance unit is ineligible until the excess income is offset through the spend-down process. Cross Reference: 5520.25 – 5520.35 – Spenddown.

UPM § 5520.20(B)(5)

The Department correctly determined that the Appellant's $585.10 applied income exceeded the MNIL for the Medicaid program of $532.00.

The Department correctly determined the Appellant must meet a spenddown to receive MAABD coverage.

The Department incorrectly determined that the Appellant's applied income exceeds the MNIL by $121.00 per month. The Appellant's applied income exceeds the MNIL by $53.10 per month. $585.10 total applied income - $532.00 MNIL = $53.10 excess income.

On [redacted] 2021, the Department incorrectly determined the Appellant's spenddown as $726.00 per month. As of [redacted] 2021, the correct spenddown amount equaled $318.60 for the 6-month spenddown period beginning [redacted] 2021 ending [redacted] 2022. ($53.10 excess income x 6 months = $318.60)

10. Department policy provides as follows:

The total amount of excess income for the entire six-month prospective period is offset by:

a. Medical expenses occurring prior to the prospective period in accordance with guidelines set forth in UPM § 5520.25 and;
b. Paid or unpaid medical expense occurring the prospective period in chronological order.

UPM § 5520.30(B)(1)

Department policy provides as follows:

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.

1. Medical expenses are used for a spend-down if they meet the following conditions:
   a. The expenses must be incurred by 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 expenses 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 eligibility being achieved.
3. Medical 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 the 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;
   c. Finally expenses incurred for necessary medical and remedial services recognized under State law as medical costs and 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 anytime prior to the three-month retroactive period; then
b. Paid or unpaid expenses incurred within the three-month restorative 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:
   a. Any portion of medical expenses used to offset the excess income are the responsibility of the unit to pay.
   b. 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.

UPM § 5520.25(B)

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

As of [redacted] 2021, the Appellant's spenddown remains as $318.60 until qualifying medical expenses are submitted to the Department and current liability determined by the Department.

DISCUSSION

Although the Appellant incurs out of pocket medical expenses, the Department correctly determined the Appellant must meet a spenddown before medical coverage can be activated. However, the Department miscalculated the amount of the Appellant's spenddown. It appears when the Appellant's son moved out of the home, the Department may have failed to re-evaluate the Appellant's eligibility for the unearned income disregard from the standard disregard to the special disregard. The Appellant is entitled to the special disregard resulting in a lower spenddown amount. Although this change does not remove the spenddown, it does lower the spenddown from $726.00 to $318.60, a significant decrease beginning [redacted] 2021. It is noted, changes to the Appellant's SSDI beginning [redacted] 2022 will impact the spenddown amount.

The Appellant must provide the Department with proof of the medical costs she incurs which are not covered by Medicare or the QMB program so that the Department may determine if such expenses are qualifying expenses under the MAABD spenddown program to activate coverage. Additional information is required to determine whether the medical documents submitted by the Appellant at the time of her hearing request are qualifying expenses. The debt collection agency documents do not list dates of service, the service provided, or third party insurance liability, such as Medicare or Medicaid. Current liability for the 2020 [redacted] Statements cannot be determined or whether any of these expenses were used for a previous spend-down period which resulted in eligibility.

DECISION

Regarding the issue as to whether the Appellant must meet a spenddown under the MAABD spenddown program before medical coverage is activated, the Appellant appeal is denied.

Regarding the secondary issue as to whether the Department calculated the Appellant's MAABD spenddown amount of $726.00 for the period [redacted] 2021 through [redacted] 2022 correctly, the Appellant's appeal is granted.

ORDER

1. Effective [redacted] 2021, the Department must recalculate the Appellant's applied unearned income by subtracting the correct unearned income disregard of $429.90, special disregard, from the Appellant's gross unearned income.

2. The Department must recalculate the Appellant's spenddown amount under the MAABD spenddown program for the six-month spenddown period beginning [redacted] 2021 through [redacted] 2022 and issue a corrected notice to the Appellant.

3. Compliance is due 14-days from the date of this hearing decision.

Lisa A. Nyren
Lisa A. Nyren
Fair Hearing Officer

CC: Musa Mohamud, Social Services Operations Manager
Judy Williams, Social Services Operations Manager
Jay Bartolomei, Eligibility Services Supervisor
Garfield White, 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, 165 Capitol Avenue, 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.