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

, 2022
Signature Confirmation

Client ID
Case ID
Request # 194084

NOTICE OF DECISION

PARTY

PROCEDURAL BACKGROUND

On 2022, the Department of Social Services (the "Department") sent the ("the Appellant") a Notice of Action ("NOA") advising that she was denied Medicaid benefits under the Medically Needy for Aged, Blind and Disabled Program - MAABD ("Husky C") under a Spend-down effective 2022.

On 2022, the Appellant requested an Administrative Hearing to contest the Department's decision to deny medical benefits.

On 2022, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the Administrative Hearing for 2022.

On 2022, 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 via teleconference.

The following individuals participated in the hearing by phone:

Appellant
Xiomara Natal, Department Representative
Jessica Gulianello, Fair Hearing Officer

The Department did not prepare a hearing summary to address the issue of this hearing and lacked evidence to support its position. The Appellant was advised of her right to receive and review the Department's summary as well as supporting documentation prior to continuing with the hearing proceedings. The Appellant declined a reschedule of the Administrative Hearing and requested to proceed in the absence of said documents. The Hearing Record was extended until [redacted] 2022, to allow the Department time to submit information. The Hearing Record further remained open until [redacted] 2022, to allow the Appellant time to provide comment and a rebuttal. Additional documents were received from both parties and on [redacted] 2022, the Hearing Record closed accordingly.

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department's decision to deny the Appellant's Medicaid benefits under Husky C effective [redacted] 2022, was correct.

It should be noted that subsequent to the Department's testimony the issue of this hearing was altered to the calculation of the Spend-down amount during the Hearing proceedings.

FINDINGS OF FACT

1. On [redacted] 2022, the Department received a completed application ("W-1E") from the Appellant requesting cash and special medical help for unpaid medical bills from the past [redacted] months. *(Exhibit 1: W-1E, Exhibit: 3: ImpaCT Document Searches, Exhibit 9: Case Notes, Department's Testimony)*

2. On [redacted] 2022, the Department received several documents from the Appellant including ID cards and proof of her out-of-pocket medical expenses.

   (Exhibit 3:Document Searches, Exhibit 4: Medical Expense Documents)

Provider:	Date(s) of Service:	Amount:	Statement Date:
[redacted]	[redacted]/2021, [redacted]/2021	$103.26 Amount Due	[redacted]/2022
[redacted]	[redacted]/2022	$3.95 Copay	[redacted]/2022
[redacted]	[redacted]/2022, [redacted]/2022, [redacted]/2022	$493.00 Payment	[redacted]/2022

3. On [redacted] 2022, the Department reviewed the W-1E and registered the Appellant's request for medical benefits in the online eligibility management system, ("ImpaCT"). *(Exhibit 10: Case Notes - [redacted]/2022, Department's Testimony, Hearing Summary)*

4. The Appellant was [redacted] years old (DOB [redacted]) at the time of application. The Appellant is presently [redacted] years old. *(Exhibit 1: W-1E, Exhibit 8: [redacted] Results Details, Exhibit 10: Case Notes – [redacted]/2022, Appellant's Testimony)*

5. The Appellant is [redacted]. *(Exhibit 1: W-1E)*

6. The Appellant has been [redacted] since [redacted] 2021. The Appellant commonly stays in a [redacted] incurring a [redacted] fee of $400 or she stays in her [redacted]. *(Exhibit 1: W-1E, Exhibit 10: Case Notes – [redacted]/2022, Appellant's Testimony)*

7. The Appellant has been determined to be disabled [redacted] [redacted]. *(Exhibit 1:W-1E, Exhibit 10: Case Notes – [redacted]/2022, Appellant's Testimony)*

8. The Appellant currently receives [redacted] benefits in the gross amount of $1,967 per month. *(Exhibit 1: W-1E, Exhibit 8: ImpaCT [redacted] Results Details, Exhibit 9: MAABD – Income Test, Exhibit 10: Case Notes, Hearing Record)*

9. On [redacted], 2022, the Department issued the Appellant a Proofs We Need form ("W-1348") requesting proof of the balances of her [redacted] and [redacted] accounts due by [redacted], 2022. *(Exhibit 2: W-1348, [redacted] 2022)*

10. On [redacted] 2022, the Department submitted an [redacted] request for proof of the Appellant's assets [redacted], ("[redacted]"). *(Exhibit 10: Case Notes- [redacted]/2022, Department's Testimony)*

11. On [redacted] 2022, the Department received the [redacted] results reflecting the Appellant owns a [redacted] account with [redacted] Bank that held a balance of $806.49 as of [redacted] 2022. *(Exhibit 5: [redacted] Results)*

12. On [redacted] 2022, the Department received documents from the Appellant indexed under the following categories: return cover sheet, verification we need form, notice of action, hearing request form, bank information, rent receipt, and unknown document. *(Exhibit 3: ImpaCT Document Searches, received date: [redacted]/2022)*

13. On [redacted] 2022, the Department received a letter of reference from [redacted] Bank confirming the Appellant is not a customer and does not hold any accounts. *(Exhibit 3: ImpaCT Document Searches, received date: [redacted]/2022, Hearing Summary)*

14. On [redacted] 2022, the Department updated the Appellant's bank accounts in ImpaCT. *(Exhibit 7: ImpaCT Liquid Assets – Summary, Exhibit 10: Case Notes - [redacted]/2022, Department's Testimony, Hearing Summary)*

15. On [redacted] 2022, the Department received a duplicate copy of the letter from [redacted] Bank, a certified mail receipt dated [redacted]/2022, and a cover sheet. *(Exhibit 3: ImpaCT Document Searches, received date: [redacted]/2022)*

16. The Appellant owns one vehicle, a [redacted]. The Department had access to this information through a [redacted] Search ([redacted]) . *(Exhibit 7: ImpaCT [redacted] Search, Exhibit 7: ImpaCT [redacted] Summary, Hearing Record)*

17. On [redacted] 2022, the Department confirmed that the Appellant is not a recipient of in-home waiver services and entered a case note stating Husky C – Home and Community-Based Services ("W01") Medicaid was pending in error and updated ImpaCT accordingly. *(Exhibit 10: Case Notes, [redacted]/2022)*

18. On [redacted] 2022, the Department sent the Appellant a NOA advising that she was approved for medical benefits under the Husky C – MAABD coverage group for the benefit period of [redacted] 2022, through [redacted] 2022, with a Spend-down amount of $917 as well as the benefit period of [redacted] 2022, through [redacted] 2022, with a Spend-down amount of $917. The NOA also informed the Appellant that she was denied benefits under the Husky C – MAABD medical coverage effective [redacted] 2022, citing failure to provide the requested proofs by the due date. *(Exhibit 5: NOA, [redacted]/2022)*

19. The Department acted following receipt of the Appellant's request for an Administrative Hearing and provided testimony asserting that the Appellant is currently eligible for a Husky C – MAABD Spend-down in the amount of $6,156 for the [redacted]-month period beginning [redacted] 2022, through [redacted] 2022. *(Department's Testimony)*

20. The Appellant passed the asset and verification tests for the Husky C – MAABD Spend-down program. *(Exhibit 9: MA – EDG Summary, [redacted]/2022)*

21. At [redacted] of application, the medically needy income limit ("MNIL") under the MAABD program was $532. *(Exhibit 9: MAABD – Income Test, [redacted]/2022)*

22. The Department determined the Appellant's total countable income to be $1,967 per month. $1,967 per month - $409 standard unearned income disregard= countable income of $1,558 per month. *(Exhibit 9: MAABD – Income Test, Department's Testimony)*

23. The Department determined the Appellant's countable income of $1,558 exceeded the Husky MNIL of $532 resulting in eligibility for medical coverage under the

MAABD Spend-down program with a Spend-down amount of $6,156 for the 6-month Spend-down period of [redacted] 2022, through [redacted] 2022.

Calculated as follows: Applied income of $1,558 – MNIL of $532 = excess income of $1,026 x 6 months = the Spend-down amount of $6,156.

(Exhibit 9: ImpaCT MAABD – Income Test, Department's Testimony)

24. On [redacted] 2022, the Department authorized the Husky C - MAABD Spend-down. *(Exhibit 9: ImpaCT Eligibility Determination Results).*

25. It is not clear if the Department properly issued the Appellant an updated NOA to advise her of her eligibility for the Husky C Spend-down effective [redacted] 2022. *(Hearing Record)*

26. The total Spend-down of $6,156 was reduced to a remaining Spend-down balance of $5,986.50. *(Exhibit 9: ImpaCT MA – EDG Summary [redacted] 2022)*

27. It is not clear if the Department applied medical bills to reduce the Spend-down amount. It is also not clear if the Appellant was properly notified. *(Hearing Record)*

28. The Department initiated a case change action in ImpaCT and as of [redacted] 2022, the Husky C Spend-down is reflected in unauthorized status. *(Exhibit 9: ImpaCT Eligibility Determination Results, [redacted]/2022)*

29. 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] 2022. This decision, therefore, was due no later than [redacted] 2022. However, the hearing record, which had been anticipated to close on [redacted] 2022, did not close for the admission of evidence until [redacted] 2022, at the request of the Appellant. Because this [redacted] day delay in the close of the hearing record arose from the Appellant's request, this final decision was not due until [redacted] 2022, and is therefore timely. *(Hearing Record)*

CONCLUSIONS OF LAW

1. Section 17b-2(6) of the Connecticut General Statutes ("Conn. Gen. Stat.") provides the following: 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. Conn. Gen. Stat. § 17b-261b(a) provides the following: the Department of Social Services shall be the sole agency to determine eligibility for assistance and services under programs operated and administered by the Department.

3. *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)) provides the following: "The department's uniform policy manual is the equivalent of a state regulation and, as such, carries the force of law."

   The Department has the authority to administer the Medicaid program.

4. Uniform Policy Manual ("UPM") § 1500.01 provides the following: "The application process is all activity related to the exploration, investigation and disposition of an application beginning with the filing of an assistance request and ending with disposition of the application."

   UPM § 1505 provides the following: "The application process outlines the general methods and requirements used in obtaining assistance and in determining an assistance unit's initial eligibility. The application process is essentially the same for all programs. It is designed to provide aid in a prompt and efficient manner those who request assistance."

   UPM § 1010 provides the following: "The assistance unit, by the act of applying for or receiving benefits, assumes certain responsibilities in its relationship with the Department. This chapter describes those responsibilities which an assistance unit assumes when it applies for or receives benefits from the Department."

   The Department correctly determined a W-1E was received on ██████ 2022, requesting Medicaid benefits.

5. UPM § 2530 provides the following: 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.

UPM § 2530.05(A) 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 § 2530.10(A) provides the following: An individual who is considered disabled by SSA is considered disabled by the Department.

The Department correctly determined the Appellant meets the disability requirement under the MAABD Husky C program as [redacted] [redacted] determined her to be disabled.

6. UPM § 2540.96(A) provides the following: 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(C) provides the following: 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 § 4530.15(A)(1) provides the following: A uniform set of income standards is established for all assistance units who do not qualify as categorically needy.

    UPM § 4530.15(A)(2) provides the following: 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(B) provides the following: 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 § 4510.10(B)(2) provides the following: The regional breakdown of the state by cities and towns is as follows: Region B: Stratford.

7. Public Act 22-118 consolidated regions A, B and C into one statewide region effective July 1, 2022. Pursuant with this Public Act the Department effective July 1, 2022, the Department uses a single statewide standard for the TFA Standard of Need rather than using different amounts for different regions of the state. These revisions make TFA payment standards, TFA grant levels, and the Husky C MNIL uniform across the state. Additionally, because the TFA Standard of Need is now tied to 55% of the Federal Poverty Level ("FPL"), these program standards and benefits will change each year.

The Department correctly determined that the MNIL for the Appellant's assistance unit of one person to be $532 in Region █ at the time of application. The Appellant is ████ and uses a ████ located in ████ for ████. The Department correctly determined the town of ████ is located in Region █.

Effective ████ 2022, the statewide MNIL (equivalent to 143% of the TFA Payment Standard) increased to $653 for an assistance unit of one person.

8. UPM § 5050.13(A)(1) provides the following: Income from these sources [Social Security] is treated as unearned income in all programs.

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

UPM § 5099.05 provides the following: Department policy provides in pertinent part: All income must be verified as an eligibility requirement at the time of application, at each redetermination of eligibility, and whenever the income changes.

The Department correctly determined the Appellant's ████ ████ benefits to be $1,967 per month.

The Department correctly determined the Appellant's monthly gross ████ income to be $1,967 per month.

9. UPM § 1015.05(c) provides the following: The Department must tell 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.

UPM § 1015.10(A) provides the following: 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.

UPM § 1500.01 provides the following: Verification is the act of confirming a fact, circumstance or condition through direct evidence or other reliable documentation or collateral contact.

UPM § 1505.40(A)(1): Provides the following: Prior to making an eligibility determination the Department conducts a thorough investigation of all circumstances relating to eligibility and the amount of benefits.

UPM § 1540.05(C)(1) provides the following: The Department requires verification of information:

a. When specifically required by Federal or State Law or regulation; and

b. When the Department considers it necessary to corroborate an assistance unit's statements pertaining to an essential factor of eligibility. .

UPM § 1540.15(A) provides the following: The information provided by the assistance unit is verified through a cooperative effort between the Department and members of the unit.

UPM § 4000.01 provides the following: A counted asset is an asset which is not excluded and either available or deemed available to the assistance unit. An available asset is cash or any item of value which is actually available to the individual or which the individual has the legal right, authority or power to obtain, or to have applied for, his or her general or medical support. The record owner of an asset is the person who has apparent ownership interest as shown on a title, registration, or other documentation. The legal owner of an asset is the person who is legally entitled to enjoy the benefit and use of the asset.

UPM § 4005.05(D) provides the following: The Department compares the assistance unit's equity in counted assets with the program asset limit when determining whether the unit is eligible for benefits.

UPM § 4005.10(A)(2)(a) provides the following: The MAABD – Categorically and Medically Needy asset limit is $1,600 for a needs group of one

UPM § 4099.05(A)(1) provides the following: The assistance unit must verify its equity in counted assets.

UPM § 4099.30(A) provides the following: The assistance unit must verify the following for the Department to evaluate each asset held by the assistance unit. This list is not necessarily all-inclusive.

1. The asset's legal owner, if there is a question of ownership, as described in 4010; and
2. The asset's status as either inaccessible or excluded, if there is a question, as described in 4015 and 4020, respectively ; and
3. The amount of equity the assistance unit has in the asset; and
4. The amount of equity in counted assets to be deemed available to the unit, as described in 4025.

The Department correctly determined proof of the Appellant's assets to be an eligibility requirement for Husky C Medicaid.

The Record reflects the Department verified the Appellant's countable assets were below the $1,600 limit through a combination of [redacted] results and documentary evidence received from the Appellant as of [redacted] 2022.

10. UPM § 4030.55 provides the following: The Department evaluates each motor vehicle owned by every member of the assistance unit in terms of the vehicle's status as an excluded, inaccessible, or counted asset.

    UPM § 4030.55 (D)(1) provides the following: For an individual and spouse if any, living together one motor vehicle is excluded if it:
    a. is needed for employment: or
    b. is needed for medical treatment of a specific or ongoing medical problem; or
    c. has been modified for operation by or transportation of a handicapped person.

    The Department verified via [redacted] that the Appellant is the owner of [redacted] vehicle, a [redacted]. The Department correctly characterized the vehicle as required for [redacted] as the Appellant has been determined to be [redacted].

11. UPM § 1505.35(C)(1) provides the following: The following promptness standards are established as maximum time periods for processing applications: c. forty-five days for AABD or MA applicants applying on the basis of age or blindness. d. ninety days for AABD or MA applicants applying on the basis of disability.

    UPM § 1540.05(D) provides the following: Consequences for failure to provide information: The penalty for failure to provide verification depends upon the nature of the factor or circumstance 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:

    a. income amounts;

    b. asset amounts

UPM § 1505.40(B)(1)(c)(1) provides the following: The following provisions apply if the applicant failed to complete the application without good cause: The applicant's failure to provide required verification by the processing due date causes one or more members of the assistance unit to be ineligible if the unverified circumstances is a condition of eligibility;

UPM § 1560.10(A) provides the following: The beginning date of assistance for Medicaid may be one of the following: the first day of the first, second or third month immediately preceding the month in which the Department receives a signed application when all non-procedural eligibility requirements are met and covered medical services are received at any time during that particular month;

The Department correctly evaluated the Appellant's eligibility for retro Medicaid for the preceding months of ████ 2022 and ████ 2022 but failed to consider the month of ████ 2021.

The Department incorrectly issued the Appellant a NOA on ████ 2022, denying the Husky C MAABD Spend-down effective ████ 2022, citing failure to provide information.

As previously stated, the Department verified the Appellant's countable assets as of ████ 2022, prior to ████ 2022, NOA.

The Department acted on the Appellant's case following her request for an Administrative Hearing and provided testimony asserting that the Appellant was subsequently determined to be eligible for a Husky C MAABD Spend-down effective ████ 2022.

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

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

    UPM § 5045.10(C)(1) provides the following: 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 § 5030.15(B)(1)(a) provides the following: The Department uses the following unearned income disregards, as appropriate under the circumstances described: Standard Disregard: 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.

The Department correctly determined the Appellant is eligible for the Standard Unearned Income Disregard.

As previously outlined the Standard Disregard increases annually to reflect the cost-of-living adjustment used by the Social Security Administration.

Per the "Income Limits & Standards for DSS Benefit Programs" as of [redacted] [redacted], the Standard Disregard is $409.

The Department correctly calculated the Appellant's applied unearned income as $1,558. ($1,967 [redacted] - $409 standard disregard= $1,558)

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

    The Department correctly determined the Appellant's total applied income as $1,558. ($0 applied [redacted] income + $1,558 applied [redacted] income + $0 deemed income= $1,558 total applied income)

14. UPM § 5520.20(B)(3) provides the following: 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 § 5515.05(C)(2) provides the following: 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 § 5515.10(C) provides the following: The income limit used to determine Medicaid eligibility is the limit for the number of persons in the needs group.

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

UPM § 5520.20(B)(5) provides the following: 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.

The Department correctly determined the Appellant's applied income of $1,558 exceeded the Husky C MNIL of $532 for the Medicaid program.

The Department correctly determined the Appellant must meet a Spend -down to receive MAABD coverage.

The Department correctly determined that the Appellant's applied income exceeded the MNIL by $1,026 per month.

Calculation as follows: Total applied income of $1,558 – the MNIL of $532 = excess income of $1,026

The Department correctly calculated the Appellant's Spend-down as $6,156 for the six-month period beginning [redacted] 2022 and ending [redacted] 2022. ($1,026 excess income x 6 months = $6,156).

It is not clear if the Department issued the Appellant a NOA to advise her of her of Husky C Spend-down eligibility effective [redacted] 2022.

As previously stated, the MNIL increased from $532 for Region [redacted] to $653 statewide effective [redacted] 2022, altering the above outlined Spend-down calculation. It is unknown if the Department issued the Appellant an updated NOA to advise of the subsequent changes to the Husky C Spend-down amount because of the increased MNIL.

15. UPM § 5520.30(B)(1) provides the following: 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 § 5520.25(B) provides the following: 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 § 5520.30(B)(3) provides the following: When the amount of incurred expense is insufficient to offset the excess income, no eligibility exists for that six-month period.

The Department provided evidence to verify that as of ██████ 2022, the Appellant's Spend-down amount of $6,156 was reduced to a remaining Spend-down amount of $5,086.50. The Department did not provide testimony and/or evidence to verify what medical bills were accepted as qualifying medical expenses and applied to reduce the remaining Spend-down balance. Furthermore, it is also not clear if the Appellant was properly notified.

16. UPM § 1570.25(C)(2)(k) provides for the Administrative Duties of Fair Hearing Official. The Fair Hearing official renders a Fair Hearing decision in the name of the Department, in accordance with the Department's policies and regulations. The Fair Hearing decision is intended to resolve the dispute.

    UPM § 1570.25(F)(2)(a) provides for Matters Considered at the Fair Hearing. The Department must consider several types of issues at an administrative hearing, including the following: eligibility for benefits in both initial and subsequent determinations.

    The Department provided testimony concerning subsequent changes to the Appellant's eligibility for the Husky C Spend-down essentially alerting the scheduled issue of this Administrative Hearing. I find the Department did not provide sufficient documentary evidence to support their updated determination.

DISCUSSION

The Department incorrectly issued the Appellant a NOA on [redacted] 2022, denying the Husky C Spend-down effective [redacted] 202, citing failure to provide information as the asset verification in question had been substantiated as of [redacted] 2022.

The Department acted following receipt of the Appellant's request for an Administrative Hearing. I find the Department correctly determined the Appellant to be eligible for a Husky C Spend-down in the amount of $6,156 for the [redacted] period beginning [redacted] 2022, ending [redacted] 2022. However, it is not clear if the Department properly informed the Appellant of her eligibility for the Husky C Spend-down as an updated NOA was not submitted to the Hearing Record.

The Husky C MNIL increased from $532 to $653 effective [redacted] 2022. It is not clear if the Department re-calculated the Husky C MAABD Spend-down and properly notified the Appellant of the applicable changes as an updated NOA was not submitted to the Hearing Record.

The total Husky C Spend-down was reduced from $6,156 to $5,086.50. It is not clear what bills the Department accepted as qualifying medical expenses. It is also not clear if the Department property notified the Appellant as an updated NOA was not submitted to the Hearing Record.

It should be noted that the Appellant requested [redacted] Medicaid for unpaid medical bills for [redacted] months on the W-1E. The Department correctly evaluated the Appellant's eligibility for [redacted] Medicaid for the months of [redacted] 2022 and [redacted] 2022. I find the Department failed to properly evaluate the Appellant's eligibility for [redacted] Medicaid for the month of [redacted] 2021 as evidenced by the NOA dated [redacted] 2022.

The Appellant had concerns in relation to her voter registration status and the amount/frequency of her shelter expenses etc. While I find these matters to be outside of the scope of this hearing the Appellant is encouraged to follow up with the Department to ensure these details are settled accordingly.

DECISION

The Appellant's Appeal is REMANDED.

ORDER

1). The Department must review the Appellant's eligibility for Medicaid for the month of [redacted] 2021 in compliance with her request for help with three months of retro medical bills as evidenced on the W1E received on [redacted] 2022.

2). The Department must review, recalculate, and authorize the Appellant's Husky C MAABD Spend-down amount with consideration of the updated MNIL effective [redacted] 2022, as it falls within the current Spend-down cycle and issue the Appellant a NOA to advise of any changes.

3). The Department must review all medical expenses provided by the Appellant from the date of application until present and issue the Appellant a NOA to confirm if the expense was accepted or rejected and verify the adjustments to the remaining spend-down amount.

4). Compliance is due within 14 days of the date of this hearing decision.

Jessica Gulianello

Jessica Gulianello
Fair Hearing Officer

CC: Xiomara Natal - ESS, Tim Latifi - SSOM, Robert Stewart – SSOM, [redacted] DSS

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.