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

[redacted] **2023**
Signature Confirmation

[redacted]
[redacted]
Hearing # 209639

NOTICE OF DECISION

PARTY

[redacted]
[redacted]
[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2022, the Department of Social Services (the "Department") sent [redacted] [redacted] (the "Appellant"), a Notice of Action ("NOA") indicating she is in a HUSKY C – Medically Needy Aged, Blind, Disabled – Spenddown ("MAABD") program and that she must meet a $5,626.00 spend-down before her medical benefits can be activated.

On [redacted] 2023, the Appellant requested an administrative hearing to contest the amount of the spend-down.

On [redacted] [redacted] 2023, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling a telephonic administrative hearing on [redacted] 2023.

On [redacted] 2023, in accordance with sections 17b-60, 17b-61 and 4-176e to 4-189, inclusive, of the Connecticut General Statutes, OLCRAH held an administrative hearing. The following individuals participated in the hearing:

[redacted] the Appellant
Chris Filek, Department's Representative
Carla Hardy, Hearing Officer

STATEMENTS OF THE ISSUE

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

The second issue is whether the Appellant must meet a spend-down before becoming eligible for medical assistance.

FINDINGS OF FACT

1. The Appellant was granted a spend-down period beginning in [redacted] 2022 and ending in [redacted] 2023. (Exhibit 2: MA-EDG Summary, Department's Testimony)

2. The Appellant received $1,967.00 in monthly Social Security Disability ("SSD") benefits from [redacted] 2022 through [redacted]2022. (Exhibit 4: SOLQ-I Results; Appellant's Testimony; Department's Testimony)

3. Effective [redacted]2023, the Appellant's monthly SSD income increased to $2,138.00. (Exhibit 4; Appellant's Testimony; Department's Testimony)

4. The SSD is the Appellant's only source of income. (Hearing Record)

5. The Appellant has a Medicare Savings Plan ("MSP") that pays for her monthly Medicare B premiums. (Exhibit 3: NOA, [redacted]/22; Department's Testimony)

6. On [redacted] 2022, the Department notified the Appellant that her income was too high to qualify for medical coverage and that she may become eligible through the spend-down process. To become eligible for healthcare coverage she must meet a spend-down of $5,626.00 for the period of [redacted] 2022, through [redacted] 2023. (Exhibit 3)

7. The Appellant is the only person in her household. (Appellant's Testimony)

8. The Appellant submitted medical bills to the Department for review. Her current spend-down has been reduced to $4,556.50. (Appellant's Testimony)

9. 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] 2023. Therefore, this decision is due no later than [redacted] 2023.

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. "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. Uniform Policy Manual ("UPM") Section 2540.01(A) provides that in order to qualify for medical assistance, an individual must meet the conditions of at least one coverage group.

4. UPM § 5500.01 provides that a needs group is the group of persons comprising the assistance unit and certain other persons whose basic needs are added to the total needs of the assistance unit members when determining the income eligibility of the assistance unit.

   UPM § 5515.05(C)(2)(a)(b) provides in part that the needs group for Medical Assistance for the Aged, Blind and Disabled ("MAABD") 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.

   UPM § 2015.05(A) provides that the assistance unit in Assistance to the Aged, Blind or Disabled ("AABD") and MAABD consists of only one member. In these programs, each individual is a separate assistance unit.

   The Department correctly determined the Appellant is in a needs group of one person and an assistance unit of one member.

5. UPM § 5050.13(A)(1) provides that income from Social Security is treated as unearned income for all programs.

   The Department correctly determined the Appellant's total gross monthly unearned income equaled $1,967.00 from [redacted] through [redacted] 2022.

   The Department correctly determined the Appellant's total gross monthly unearned income equaled $2,138.00 in [redacted] and [redacted] 2023.

6. 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.

   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.

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

   Effective January 1, 2022, the standard disregard equaled $409.00.

   Effective January 1, 2023, the current standard disregard equaled $482.00.

   The Department correctly calculated the Appellant's applied income equaled $1,558.00 ($1,967.00 SSD - $409.00 Standard Disregard = $1,558.00) in [redacted] 2022 through [redacted] 2022.

   The Department correctly calculated the Appellant's applied income equaled $1,656.00 ($2,138.00 SSD - $482.00 Standard Disregard = $1,656.00) effective [redacted] 2023.

7. 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.

   The Department correctly calculated the Appellant's six-month period of eligibility as [redacted] 2022, through [redacted] 2023.

8. UPM § 4530.15(A) pertains to the medical assistance standards. (1) A uniform set of income standards is established for all assistance units who do not qualify as categorically needy. (2) The Medically Needy Income Limit ("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 for the standard of assistance. The medically needy income limit is the amount equivalent to 143 percent of the benefit

amount that ordinarily would be paid under the TFA program to an assistance unit of the same size with no income for the appropriate region of residence.

The monthly Temporary Family Assistance grant for one person is $456.00.

The MNIL for one person is $653.00 ($456.00 X 143% = $653.00).

The Department correctly determined the MNIL for a needs group of one is $653.00.

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

The Appellant's monthly applied income exceeded the MNIL by $905.00 ($1,558.00 applied income - $653.00 MNIL = $905.00) for a period of four months, [redacted] 2022, through [redacted] 2022.

The Appellant's monthly applied income exceeded the MINIL by 1,003.00 ($1,656.00 applied income - $653.00 = $1,003.00) for two months, [redacted] 2023, and [redacted] 2023.

The Department correctly calculated that during the six-month period from [redacted] 2022 through [redacted] 2023, the Appellant's applied income exceeded the MNIL by $5,626.00 [($905.00 x 4) + ($1,003.00 x 2) = $5,626.00).

10. UPM § 5520.25(B)(1) 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 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 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 <u>not</u> 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. <u>unpaid</u> expenses incurred anytime prior to the three-month retroactive period; then
   b. <u>paid or unpaid</u> 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:
   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 that when the amount of incurred expense is insufficient to offset the excess income, no eligibility exists for that six month period.

On [redacted], 2022, the Department correctly determined that the Appellant must meet a $5,626.00 spend-down to become eligible for MAABD.

DISCUSSION

The Appellant has since submitted medical bills that reduced her spend-down from $5,626.00 to $4,556.50.

DECISION

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

Carla Hardy
Carla Hardy
Hearing Officer

Pc: Brian Sexton, Office Manager, Chris Filek, Hearing Liaison, Department of Social Services, Middletown

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, 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 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.