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

Case ID # [redacted]
Client ID # [redacted]
Request # 218620

NOTICE OF DECISION

PARTY

[redacted]
[redacted]
[redacted]
[redacted],[redacted]

PROCEDURAL BACKGROUND

On [redacted], 2023, the Department of Social Services ("the Department") issued [redacted] ("the Appellant") a Notice of Action ("NOA") discontinuing her coverage under the Husky C Medicaid for the Working Disabled ("Med-Connect") program, effective [redacted] 2023, because her income exceeds the program limit.

On [redacted] 2023, the Appellant requested an administrative hearing because she disagrees with the Department's discontinuance of her Med-Connect coverage.

On [redacted] 2023, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for July 31, 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], Appellant
Christine Faucher, Department's Representative
Kristin Haggan, Fair Hearing Officer

STATEMENT OF THE ISSUE

The issue is whether the Department correctly discontinued the Appellant's Med-Connect coverage, effective [redacted], 2023, because her income exceeds the program limit.

FINDINGS OF FACT

1. The Appellant is [redacted] years old (DOB [redacted]) and is not married. *(Appellant's Testimony, Hearing Record)*

2. The Appellant is disabled and receives a monthly gross Social Security Retirement ("SSA") benefit of $1628.90. *(Appellant's Testimony, Exhibit 4: Unearned Income Details, Exhibit 5: SOLQ Results Details)*

3. The Appellant was covered under the Med-Connect program through [redacted] 2023. (*Hearing Record)*

4. From [redacted], 2023, through [redacted] 2023, the Appellant was on a leave of absence from her job at Hartford Healthcare Natchaug Hospital. She received short-term disability payments during this time. (*Appellant's Testimony)*

5. On [redacted] 2023, the Appellant submitted an Online Change Report ("ONCH"). The Appellant reported on the ONCH that she was working for [redacted] making $34.94 per hour for 40 hours per week until she began a leave of absence on [redacted] 2023. She reported that her earned income would end on [redacted], 2023. (*Exhibit 1: ONCH*)

6. The Department received the Appellant's ONCH on [redacted], 2023, and processed it on [redacted], 2023. The Department reviewed Theworknumber.com and the Appellant's three most recent bi-weekly gross wages from [redacted] /23 $2795.10, [redacted] /23 $2795.10, and [redacted] /23 $2795.10). The Department used an anticipated gross income of $2795.10 for the [redacted] /23 pay date. The Department calculated the Appellant's prospective monthly gross earned income average as $6009.47 ($2795.10 x 2.15) and entered it in the Impact system. The Department did not ask the Appellant for verification of her income ending or her leave of absence. (*Hearing Summary, Department's Testimony, Exhibit 2: Theworknumber Wage Verification, Exhibit 6: MAABD Income Test*)

7. On [redacted] 2023, the Department calculated the Appellant's total monthly gross income as $7638.37 (SSA $1628.90 + Earned Income $6009.47). The Department determined that the Appellant was over the Med-Connect gross monthly income limit of $6250.00, and issued the Appellant an NOA informing her that it was discontinuing her coverage effective [redacted] 2023. (*Exhibit 7: NOA, Department's Testimony*)

8. On [redacted], 2023, the Department reviewed Theworknumber.com website which showed that the Appellant was on a leave of absence from her job at [redacted] and that her gross bi-weekly payments had decreased effective [redacted], 2023 ([redacted]/23 $1665.53, [redacted]23 $1677.06, [redacted]/23 $1677.06, and [redacted]23 $1677.06). The Department left the Appellant's Med-Connect coverage in a closed status and did not update her income. (*Exhibit 2, Department's Testimony*)

9. The issuance of this decision is timely under Section 17b-61(a) of the Connecticut General Statutes, which provides that the agency shall issue a decision within 90 days of receipt of a request for an administrative hearing. The Appellant requested an administrative hearing on [redacted], 2023. OLCRAH held an administrative hearing on [redacted] 2023, therefore, this decision is due no later than [redacted], 2023. *(Hearing Record)*

CONCLUSIONS OF LAW

1. Section 17b-260 of the Connecticut General Statutes provides for the administration of the Medicaid program pursuant to Title XIX of the Social Security Act.

2. Section 17b-597(a) of the Connecticut General Statutes provides the Department of Social Services shall establish and implement a working persons with disabilities program to provide medical assistance as authorized under 42 USC 1396a(a)(10)(A)(ii), as amended from time to time, to persons who are disabled and regularly employed. (b) The Commissioner of Social Services shall amend the Medicaid state plan to allow persons specified in subsection (a) of this section to qualify for medical assistance. The amendment shall include the following requirements: (1) That the person be engaged in a substantial and reasonable work effort as determined by the commissioner and as permitted by federal law and have an annual adjusted gross income, as defined in Section 62 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, of no more than seventy-five thousand dollars per year; (2) a disregard of all countable income up to two hundred per cent of the federal poverty level; (3) for an unmarried person, an asset limit of ten thousand dollars, and for a married couple, an asset limit of fifteen thousand dollars; (4) a disregard of any retirement and medical savings accounts established pursuant to 26 USC 220 and held by either the person or the person's spouse; (5) a disregard of any moneys in accounts designated by the person or the person's spouse for the purpose of purchasing goods or services that will increase the employability of such person, subject to approval by the commissioner; (6) a disregard of spousal income solely for purposes of determination of eligibility; and (7) a contribution of any countable income of the person or the person's spouse which exceeds two hundred per cent of the federal poverty level, as adjusted for the appropriate family size, equal to ten per cent of the excess minus any premiums paid from income for health insurance by any family member, but which does not exceed the maximum contribution allowable under Section 201(a)(3) of Public Law 106-170, as amended from time to time. (c) The Commissioner of Social Services shall implement the policies and procedures

necessary to carry out the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal within twenty days after implementation. The commissioner shall define "countable income" for purposes of subsection (b) of this section which shall take into account impairment-related work expenses as defined in the Social Security Act. Such policies and procedures shall be valid until the time final regulations are effective.

The Department has the authority to administer and determine eligibility for the HUSKY C Medicaid for the Working Disabled program.

3. "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)).

4. Uniform Policy Manual ("UPM") § 5520.33 provides for the gross income test. Income eligibility for working individuals with disabilities is determined by subjecting the individual's gross income to the limit established by the State Legislature. As of July 1, 2002, an individual's gross income limit is $6,250.00 per month, or $75,000.00 per year.

   The Department correctly applied the gross monthly income limit of $6,250.00 per month when determining the Appellant's eligibility for the Husky C Medicaid for the Working Disabled program.

5. UPM § 5050.13(A)(1)(2) provides for the treatment of specific types of benefits (SSA, SSI, V.A.). (A) Social Security and Veteran's Benefits. (1) Income from these sources is treated as unearned income in all programs. (2) This income is subject to unearned income disregards in the AABD and MAABD programs.

   The Department correctly considered the Appellant's monthly SSA benefit of $1628.90 as unearned income.

6. UPM § 5000.01 provides for gross earned income, which is the total amount of counted earned income before deductions or disregards are subtracted from it. When earnings are from self-employment, the gross amount is the difference between self-employment income and self-employment expenses.

   UPM § 5025.05(B)(2) provides for a prospective budgeting system. If income is received on other than a monthly basis, the estimate of income is calculated by multiplying 4.3 by a representative weekly amount that is determined as follows:

   a. if income is the same each week, the regular weekly income is the representative weekly amount;

   b. if income varies from week to week, a representative period of at least four consecutive weeks is averaged to determine the

representative weekly amount;

c. if there has been a recent change or if there is an anticipated future change, the amount expected to represent future income is the representative weekly amount;

d. if income is received on other than a weekly or monthly basis, the income is converted to a representative weekly amount by dividing the income by the number of weeks covered;

On [redacted] 2023, the Department incorrectly used previous bi-weekly gross wages found on Theworknumber.com to calculate the Appellant's prospective budget. The Department failed to consider the changes that the Appellant reported regarding her leave of absence status and her earned income ending.

On [redacted], 2023, the Department failed to consider if the Appellant was eligible for the Med-Connect program when it reviewed Theworknumber.com and verified that she was on a leave of absence from her job and that her income had decreased effective [redacted], 2023.

7. UPM § 5520.33 (B) provides for an applied income test. Individuals who do not pass the gross income test described in UPM § 5520.33 (A) are subject to an applied income test.

    1. The applied income limit is $3082.50 per month.

    2. An individual who passes the applied income test meets the income eligibility requirement for working individuals with disabilities.

    3. Applied income consists of the gross income of the individual minus the disregards and deductions described at 2540.85.

    UPM § 2540.85 provides that there are two distinct groups of employed individuals between the ages of 18 and 64 inclusive who have a medically certified disability or blindness and who qualify for Medicaid as working individuals with disabilities. These groups are the Basic Insurance Group and the Medically Improved Group. There is a third group of employed individuals consisting of persons at least 18 years of age who have a medically certified disability or blindness who also qualify for Medicaid as working individuals with disabilities. This is the Balanced Budget Act Group. Persons in this third group may be age 65 or older.

    UPM § 2540.85(C) provides for the Working Individuals with Disabilities Balanced Budget Act Group as follows:

    1. An individual in this group, which is authorized under the Balanced Budget Act of 1997 (BBA), is subject to the same conditions described in section 2540.85 A concerning employment status, income eligibility tests, asset eligibility tests and computation of premiums.

2. An individual in this group who is age 65 or older is eligible for Medicaid as long as he or she meets all the eligibility requirements of section 2540.85 A and has a medically certified disability or blindness.

UPM § 2540.85 (A)(2) provides that the individual meets the income eligibility test under this group by passing one of the following income tests:

a. having a gross monthly income equal to or less than $6250; or

b. having an applied monthly income (gross income minus the following; a $20 general disregard; the first $65 of gross monthly earnings; Impairment Related Work Expenses described in UPM § 5035.10 (C), if applicable; and ½ the remaining earnings) equal to or less than $3082.50.

The Appellant is eligible for Medicaid as a working individual with a disability under the Balanced Budget Act Group.

The Department failed to consider the applied income test.

8. UPM § 5035.10 (C) provides for Impairment Related Work Expenses.

1. Certain work expenses which are related to enabling the individuals to be employed are deducted from earned income in determining eligibility and calculating benefits for:

    a. recipients of assistance to the disabled; and

    b. recipients of assistance to the aged who received assistance to the disabled in the month before they became 65 years of age;

2. Impairment-related work expenses are not used to determine the initial eligibility of an applicant for assistance based upon disability.

3. Impairment-related work expenses include, but are not limited to, the following:

    a. attendant services including help with personal or employment functions;

    b. medical equipment such as canes, crutches, pacemakers, and hemodialysis equipment;

    c. prosthetic devices;

    d. work-related equipment which enables the individual to function on the job such as one-hand typewriters, telecommunication devices for the deaf, and special tools necessitated by the impairment;

    e. modifications to the residence of the individual which can be associated with maintaining employment in or outside the home,

except when claimed as a business expense by a self-employed person;

f. non-medical equipment which can be associated with enabling the individual to be employed;

g. drugs and medical services directly related to reducing, controlling or eliminating an impairment or its symptoms;

h. all other miscellaneous expenses not cited above but which can be associated with the individual's disability and with enabling the individual to be employed including transportation, medical supplies, vehicular medications, etc;

i. the cost of installing, repairing, and maintaining the cited equipment and supplies.

4. Impairment-related work expenses may be deducted when the following conditions have been met:

a. The unit member must be:

(1) considered disabled or blind, according to SSI criteria; and

(2) less than sixty-five years of age or, if sixty-five or more years of age, must have received SSI in the month before the individual became sixty-five.

b. The expenses must be for items or services which are necessary to enable the individual to maintain gainful employment;

c. Deductions are allowed for payment made by the unit member which are not reimbursable by third party coverage;

d. The amounts paid for the items or services must be:

(1) not more than the rate paid by the Medicare program; or

(2) if the Medicare rate is exceeded, not more than the prevailing rate charged in that particular community;

e. Both need for the item or service and payment made must be verified;

f. The expense must be incurred or paid after 11/30/80.

5. Expenses incurred for impairment-related work needs may be allocated in the following ways:

a. Both recurrent expenses and installment payment are deducted;

b. Down-payments may be prorated over twelve months starting with the month of payment or used in the month paid;

c. Payment made for an item during the eleven months preceding the initial month of employment can be prorated over twelve months starting with the month of payment. Only portions allocated to months of employment are deducted.

The Department failed to inquire if the Appellant had impairment-related work expenses.

9. "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 § 1015.10(A)

"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 § 1015.05(C)

The Department failed to issue the Appellant a request for verification of the changes she reported regarding her leave of absence status and income ending, and it incorrectly discontinued her Med-Connect coverage effective [redacted] 2023.

The Department failed to issue the Appellant a request for verification of any impairment-related work expenses.

DISCUSSION

On [redacted] 2023, the Department updated the Appellant's prospective income using the previous pay period's wage information obtained from Theworknumber.com, and it closed her Med-Connect coverage. Theworknumber.com is a website that does not always reflect the most up-to-date information. The Department did not give the Appellant an opportunity to verify the changes that she reported. The Department should have issued the Appellant a W-1348 request for verification of the changes that she reported.

The Department failed to consider the applied income test and failed to inquire if the Appellant had any impairment-related work expenses.

The Department reviewed Theworknumber.com again on [redacted] 2023, while preparing the hearing summary, and found that the website had updated the Appellant's employment status at Hartford Healthcare Natchaug Hospital to reflect that she was on a leave of absence and that her income had decreased effective [redacted], 2023. The Department failed to reopen the Appellant's Med-Connect coverage to determine if she was income eligible.

The Appellant reported during the hearing that effective [redacted] 2023, her employment at [redacted] ended and that her short-term disability payments ended. She reported that she would begin a new job on [redacted], 2023, earning $15.00 per hour for 20-30 hours per week. The undersigned encourages the Department to take appropriate action to verify and update this newly reported information and determine the Appellant's ongoing Med-Connect eligibility.

DECISION

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

ORDER

1) The Department is ordered to reopen the Appellant's Husky C Medicaid for the Working Disabled effective [redacted] 2023, and review eligibility based on the information that it obtained from Theworknumber.com. The Department should request any additional information from the Appellant that is needed to determine her eligibility.

2) Compliance is due to the undersigned no later than seven (7) days from the date of this decision.

Kristin Haggan
Kristin Haggan
Fair Hearing Officer

CC: Angelica Branfalt, SSOM, Manchester Regional Office
Nawaz Shaikh, Fair Hearings Supervisor, Manchester Regional Office
Javier River, Fair Hearing Liaison, Manchester Regional Office
Christine Faucher, Fair Hearing Liaison, Manchester 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, law, and 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 the 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 the 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 if 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 her designee in accordance with §17b-61 of the Connecticut General Statutes. The Agency's decision to grant an extension is final and 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.