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

[redacted], 2024
Signature Confirmation

Case ID #[redacted]
Client ID #[redacted]
Request # 242288

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2024, the Department of Social Services ("the Department") issued [redacted] ("the Appellant") a Notice of Action ("NOA") denying her application for the Husky C Medicaid for the Working Disabled program due to not meeting the program requirements.

On [redacted] 2024, the Appellant requested an administrative hearing because she disagrees with the Department's denial of her application.

On [redacted] 2024, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2024.

On [redacted], 2024, 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
[redacted], Appellant's Witness, [redacted]
Marybeth Mark, Department's Representative
Kristin Haggan, Fair Hearing Officer

The hearing record was held open for [redacted] to allow the Department to provide additional documents. The undersigned received the documents from the Department and closed the hearing record on [redacted], 2024.

STATEMENT OF THE ISSUE

The issue is whether the Department correctly denied the Appellant's application for the Husky C Medicaid for the Working Disabled program due to not meeting the program requirements.

FINDINGS OF FACT

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

2. The Appellant suffers from anxiety, major depressive disorder, and post-traumatic stress disorder. She has not been deemed disabled by the Social Security Administration. *(Appellant's Testimony, Hearing Record)*

3. If an individual has not been deemed disabled by the Social Security Administration and is employed despite their claim of having a disability, then the individual must be determined disabled by the Department to receive benefits under the Medicaid for the Working Disabled program. Colonial Cooperative Care ("CCC") is contracted by the Department to perform disability determinations. (*Hearing Record*, *Policy Transmittal No. UP-00-22)*

4. On [redacted], 2023, the Department received a W-300MED form completed by the Appellant's doctor. The form is titled "Medical Report (For Medicaid for the Employed Disabled)". CCC reviewed this form and determined the Appellant disabled with a condition onset date of [redacted] 2021, and a redetermination date of [redacted] 2024. *(Department's Testimony, Exhibit 10: CCC Determination)*

5. The Department granted the Appellant benefits under the Husky C Medicaid for the Working Disabled program for the period of [redacted] 2023, through [redacted], 2024. (*Hearing Record, Department's Testimony, Exhibit 1: MA Edge Summary)*

6. On [redacted] 2024, the Appellant submitted an online application ("ONAP") for Husky C Medicaid for the Working Disabled. (*Exhibit 7: ONAP*)

7. On [redacted] 2024, the Department reviewed the Appellant's ONAP and issued her a W1348 letter requesting proof of employment, income, and assets. (*Department's Testimony, Hearing Summary, Exhibit 3: W1348*)

8. On [redacted] 2024, the Department issued a NOA informing the Appellant that it was denying her application for Husky C Medicaid for the Working Disabled because she failed to provide all requested verifications of income and assets and failed to meet the program requirements. (*Department's Testimony, Exhibit 6: Case Notes, Exhibit 4: NOA*)

9. On [redacted] 2024, the Appellant contacted the Department and spoke regarding the verifications she submitted as proof of her employment, income, and assets. The Department verified the Appellant's current income from [redacted] per The Work Number website. The Appellant notified the Department that she had not received a medical packet. The Department sent CCC a W302 form requesting that a medical packet be sent to the Appellant. (*Exhibit 6, Department's Testimony*)

10. The Department completes a W302 "Disability/Unemployability/Emergency Medical Routing Slip" form and submits it to CCC when requesting that a disability review be completed for an individual. The Department should indicate on the W302 form the particular program that the Individual is applying for, and then CCC issues a medical packet for that specific program to the individual so it can be completed by the individual's physician. The "Referral Type" options listed on the W302 form are: SAGA Initial Review, SAGA Redetermination, Resubmission of Previously Undetermined, S05 Med-ConneCT Initial Review, S05 Med-ConneCT Redetermination, Title XIX Disability Determination, Title XIX Disability Redetermination, and Emergency Medical. ("S05 Med-ConneCT" refers to the Medicaid for the Working Disabled program). When the Department specifies that an individual is requesting SAGA Cash CCC should issue the individual a W300SA form to be completed. When the Department specifies that an individual is requesting Medicaid for the Working Disabled then CCC should issue the individual a W300MED form to be completed. (*Department's Testimony, Hearing Record, Regional Office Forms Index W302 Form*)

11. The Department could not locate a copy of the W302 form that it issued to CCC on [redacted] 2024. (*Department's Testimony*)

12. On [redacted] 2024, CCC received the W302 form from the Department and mailed the Appellant a W300SA SAGA Cash medical packet to be completed. (*Exhibit 6*)

13. On [redacted] 2024, CCC received a W300SA "Medical Report (For SAGA Cash Benefits)" form completed by the Appellant's doctor. CCC reviewed the form and stated that the "MD indicates applicant is unable to work 2 months or more but less than 6 months, short term impairment, CCC review not needed, case referred to DSS". (*Exhibit 6, Exhibit 8: W300SA Medical Report for SAGA Cash Benefits*)

14. On [redacted] 2024, the Department issued a NOA denying the Appellant's application for the Medicaid for the Working Disabled program due to failure to meet the program requirements because the Appellant lacks a disability determination from either the Social Security Administration or CCC. (*Exhibit 5: NOA, Department's Testimony*)

15. The Department received all requested verification of income and assets from the Appellant. (*Hearing Summary, Department's Testimony*)

16. 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] 2024. OLCRAH held an administrative hearing on [redacted] 2024. The hearing record was held open for [redacted] to allow the Department to submit additional documents. The record closed on [redacted] 2024; therefore, this decision is due no later than [redacted] 2024. *(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. 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.

   For the period of [redacted] 2023, through [redacted] 2024, the Department determined that the Appellant was eligible for Medicaid as a working individual with a disability under the Basic Insurance Group.

   The Department was unable to determine if the Appellant was disabled for the period beginning [redacted] 2024.

5. UPM § 2530.05 (A) provides that 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. The individual must be found to have an impairment which:
   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 (B) provides that except as provided in paragraph C below, the medical criteria the Department uses for determining disability are the same as those used for evaluating disability under SSI in accordance with 20 CFR Chapter III Appendices 1 and 2.

   UPM § 2530.05 (C) provides that under the Medicaid coverage group "Working Individuals with Disabilities," the individual must have a medically determinable impairment. However, the individual's ability to perform substantial gainful activity has no effect on the disability determination (Cross Reference: 2540.85).

In order to qualify for Husky C Medicaid for the Working Disabled coverage, individuals must have a disability approved by the Social Security Administration, or a disability approved by CCC.

6. "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 the appropriate W300MED medical packet to be completed by her doctor.

   The Department failed to request that CCC issue the Appellant the appropriate W300MED medical packet to be completed by her doctor.

DISCUSSION

The Department submitted a W302 form to CCC indicating which program the Appellant was applying for and requesting that a medical packet be issued to the Appellant. The Department could not locate a copy of the W302 form that was issued to CCC; therefore, it is unclear what was requested on the form.

The Appellant applied for the Medicaid for the Working Disabled program. The Appellant did not apply for SAGA Cash.

The Appellant received the incorrect W300SA SAGA Cash form, had her doctor complete the form, and forwarded it to CCC as she was instructed to do. CCC reviewed the form and determined that a medical review was not needed for SAGA Cash. CCC did not complete a disability review and forwarded the case back to the Department.

The Department did not provide the Appellant with the appropriate W300MED form which is needed to determine if she has a disability and is eligible for the Medicaid for the Working Disabled Program. Without the completion of this form, the Department cannot appropriately determine if the Appellant is eligible for this program.

The Department incorrectly denied the Appellant's application for the Medicaid for the Working Disabled Program.

DECISION

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

ORDER

1) The Department is ordered to reopen the Appellant's [redacted] 2024, application for the Husky C Medicaid for the Working Disabled, issue her the appropriate documents to be completed for that program, and request any additional information from the Appellant that is needed to determine her eligibility. The Department must give the Appellant ten (10) days to provide the requested verifications.

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: Matthew Kalarickal, SSOM, Norwich
Marybeth Mark, Hearing Liaison, Norwich

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.