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

[redacted] **2018**
Signature Confirmation

Client ID # [redacted]
Hearing Request #115897

NOTICE OF DECISION
PARTY

[redacted]

PROCEDURAL BACKGROUND

[redacted], 2018, the Health Insurance Exchange Access Health CT ("AHCT") sent [redacted] (the "Appellant") a Notice of Action ("NOA") discontinuing the Medicaid/HUSKY A Transitional Medical Assistance ("TMA") healthcare coverage for himself [redacted] (the "wife") effective [redacted], 2018.

[redacted], 2018, the Appellant requested a hearing to contest the Department's discontinuance of the TMA.

[redacted], 2018, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2018.

[redacted], 2018, in accordance with sections 17b-60, 17b-264, and 4-176e to 4-189, inclusive, of the Connecticut General Statues, Title 45 of the Code of Federal Regulations ("CFR") §§ 155.510 and/or 42 CFR § 457.1130, OLCRAH held a telephone administrative hearing. The following individuals participated in the hearing:

[redacted], Appellant's wife and representative
Cathy Davis, AHCT Representative
Veronica King, Hearing Officer

The hearing record remained open for the submission of additional information. On [redacted] 2018, the hearing record closed.

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department correctly discontinued the TMA effective [redacted], 2018.

FINDINGS OF FACT

1. The Health Insurance Exchange Access Health CT ("AHCT") is an agent of the Department of Social Services ("DSS"). (Hearing Record)

2. The Appellant files taxes as married filling together and claims minor son as only dependent. This is a household of [redacted]. (Exhibit 1: Application [redacted] and Appellant's Testimony)

3. The Appellant and his wife were granted TMA effective [redacted] 2017. The [redacted] 2017, NOA also stated that their TMA coverage end date was [redacted], 2018. (Exhibit 4: Health care application [redacted] and Hearing Record)

4. The Appellant's son was granted Medicaid Husky A – Children coverage with end date of [redacted], 2018. (Exhibit 4)

5. The Appellant and his wife received TMA healthcare coverage from [redacted], 2017 through [redacted] 2018. (Exhibit 4)

6. The Appellant and his wife received TMA for eleven months. (Fact 4)

7. Based on information reported by the Appellant, AHCT determined that the total household's Modified Adjusted Gross Income ("MAGI") amount was $3,691.33 per month (Appellant's $667.57 + wife $3,023.76). (Exhibit 1)

8. [redacted] 2018, AHCT issued a notice discontinuing the TMA coverage for the Appellant and his wife, effective [redacted], 2018. The notice also stated that the Appellant's minor child qualified for TMA coverage effective [redacted], 2018 till [redacted] 2019. (Exhibit 3: NOA, [redacted])

9. [redacted] 2018, the Appellant earnings were $712.08 MAGI per month computed as follows: [redacted]17 $155.55 + [redacted]17 $155.25+ [redacted]18 $196.65+ [redacted]/18 $155.25 = $662.40/4 = $165.6 * 4.3 = $712.08. (Appellant's Exhibit B: Appellant's wage stubs)

10. The Appellant's wife has a 401K account and contributes biweekly. (Appellant's Exhibit A: wife's wage stubs)

11. [redacted] 2018, the Appellant's wife earnings were $3,015.33 MAGI per month computed as follows: [redacted]17 $1,429.22(-401K$71.46) +[redacted]/17 $1,605.21(-401K$80.26) +[redacted]18 $1,420.16(-401K$71.01) +[redacted]/18 $1,450.59(-401K$72.53) = $5,609.92/4 = $1,402.48 biweekly *2.15 = $3,015.33. (Appellant's Exhibit A)

12. [redacted] 2018, the total household MAGI gross income was $3,727.41 per month. (Facts 8 and 10)

13. [redacted] 2018, the Federal Poverty Limit ("FPL") for a three people household was $1,702.00. (Federal Register)

CONCLUSIONS OF LAW

1. Section 17b-260 of the Connecticut General Statutes ("CGS") provides for acceptance of federal grants for medical assistance. The Commissioner of Social Services is authorized to take advantage of the medical assistance programs provided in Title XIX, entitled "Grants to States for Medical Assistance Programs", contained in the Social Security Amendments of 1965 and may administer the same in accordance with the requirements provided therein, including the waiving, with respect to the amount paid for medical care, of provisions concerning recovery from beneficiaries or their estates, charges and recoveries against legally liable relatives, and liens against property of beneficiaries.

2. Section 17b-264 of the CGS provides for the extension of other public assistance provisions. All of the provisions of sections 17b-22, 17b-75 to 17b-77, inclusive, 17b-79 to 17b-83, inclusive, 17b-85 to 17b-103, inclusive, and 17b-600 to 17b-604, inclusive, are extended to the medical assistance program except such provisions as are inconsistent with federal law and regulations governing Title XIX of the Social Security Amendments of 1965 and sections 17b-260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, and 17b-357 to 17b-361, inclusive.

3. Title 45 of the Code of Federal Regulations ("CFR") § 155.505(c)(1) provides that Exchange eligibility appeals may be conducted by a State Exchange appeals entity or an eligible entity described in paragraph (d) of this section that is designated by the Exchange, if the Exchange establishes an appeals process in accordance with the requirements of this subpart.

4. 45 CFR § 155.505(d) provides that an appeals process established under this subpart must comply with § 155.110(a).

5. 45 CFR § 155.110(a) provides that the State may elect to authorize an Exchange established by the State to enter into an agreement with an eligible entity to carry out one or more responsibilities of the Exchange. Eligible entities are: (1) an entity: (i) Incorporated under, and subject to the laws of one or more States; (ii)

That has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and (iii) Is not a health insurance issuer or treated as a health insurance issuer under subsection (a) or (b) of section 52 of the Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or (2) The State Medicaid agency, or any other State agency that meets the qualifications of paragraph (a)(1) of this section.

6. 26 CFR § 1.36B-1(e)(1) provides in general, household income means the sum of-
   (i) A taxpayer's modified adjusted gross income (including the modified adjusted gross income of a child for whom an election under section 1(g)(7) is made for the taxable year);
   (ii) The aggregate modified adjusted gross income of all other individuals who-
      (A) Are included in the taxpayer's family under paragraph (d) of this section; and
      (B) Are required to file a return of tax imposed by section 1 for the taxable year.

7. 42 CFR § 435.603 (f)(2)(iii) pertains to household and provides Basic rule for individuals claimed as a tax dependent. In the case of an individual who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the household is the household of the taxpayer claiming such individual as a tax dependent, except that the household must be determined in accordance with paragraph (f)(3) of this section in the case of Individuals under the age specified by the State under paragraph (f)(3)(iv) of this section who expect to be claimed as a tax dependent by a non-custodial parent.

8. AHCT correctly determined that Appellant has a household of three people.

9. 42 CFR § 435.603(e) provides that MAGI-based income means income calculated using the same financial methodologies used to determine modified adjusted gross income as defined in section 36B(d)(2)(B) of the Code, with the following exceptions-

   (1) An amount received as a lump sum is counted as income only in the month received.
   (2) Scholarships, awards, or fellowship grants used for education purposes and not for living expensed are excluded from income.
   (3) American Indian/Alaska Native exceptions.

10. Section 36B(d)(2)(B) of the Internal Revenue Code (the "Code") provides that the term "modified adjusted gross income" means adjusted gross income increased by-
    (i) Any amount excluded from gross income under section 911,
    (ii) Any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax, and
    (iii) An amount equal to the portion of the taxpayer's social security benefits (as defined in section 86(d)) which is not included in gross income under section 86 for the taxable year.

11. AHCT correctly determined the Appellant's MAGI equals $3,691.33 per month based on the reported income at time of renewal application.

12. Title 42 CFR § 435.603(d)(1)(4) provides for the application of the household's modified adjusted gross income ("MAGI"). The household's income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household. Effective January 1, 2014, a state must subtract an amount equivalent to 5 percentage points of the Federal Poverty Level for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard using MAGI-based methodologies.

13. Five percent of the FPL for a family of three is $85.1 per month ($1,702.00 x .05).

14. The Appellant's household's applicable MAGI for a household of three based on the reported income at time of application was $3,606.23 ($3,691.33 - $85.10) per month.

15. Title 42 CFR § 435.110(b)(c)(2)(i) provides that the agency must provide Medicaid to parents and caretaker relatives whose income is at or below the income standard established by the agency in the State Plan.

16. Title 42 CFR § 435.118(b)(2)(ii) provides that the agency must provide Medicaid to children under age 19 whose income is at or below the income standard established by the agency in its State Plan.

17. Public Act 15-5 June Sp. Session, Section 370 (a) provides in part Except as provide in section 17b-277, as amended by this act, and section 17b-292, as amended by public act 15-69 and this act, the medical assistance shall be provided to persons under the age of nineteen with household income up to one hundred ninety-six per cent of the federal poverty level without an asset limit and to persons under the age of nineteen, who qualify for coverage under Section 1931 of the Social Security Act, with household income not exceeding one hundred ninety-six per cent of the federal poverty level without an asset limit, and their parents and needy caretaker relatives, who qualify for coverage under

Section 1931 of the Social Security Act, with household income not exceeding one hundred fifty per cent of the federal poverty level without an asset limit.

18. One hundred fifty percent of the FPL for a household of three is $2,553.00 per month ($1,702.00 x 1.50).

19. One hundred Ninety-six percent of the FPL for a household of three is $3,335.92 per month ($1,702.00 x 1.96).

20. The Appellant's household's applicable MAGI household income of $3,606.23 per month exceeds the income threshold for Medicaid Husky A for Parents and Caretakers for a household of three, $2,553.00.

21. The Appellant's household applicable MAGI household income of $3,606.23 per month exceeds the income threshold for Medicaid Husky A for Children under 19th birthday for a household of three, $3,335.92.

22. Conn. Gen Statutes 17b-261(f) provide (f) To the extent permitted by federal law, Medicaid eligibility shall be extended for one year to a family that becomes ineligible for medical assistance under Section 1931 of the Social Security Act due to income from employment by one of its members who is a caretaker relative or due to receipt of child support income. A family receiving extended benefits on July 1, 2005, shall receive the balance of such extended benefits, provided no such family shall receive more than twelve additional months of such benefits.

23. UPM § 2540.09 (A) (1) provides that the group of people who qualify for Extended Medical Assistance includes members of assistance units who lose eligibility for HUSKY A for Families ("F07") (cross reference: 2540.24) under the following circumstances:

    the assistance unit becomes ineligible because of hours of, or income from, employment; or the assistance unit was discontinued, wholly or partly, due to new or increased child support income.

24. UPM § 2540.09 (B) (1) provides that individuals qualify for HUSKY A under this coverage group for the twelve month period beginning with the first month of ineligibility for F07.

25. The Appellant and his wife received Extended Medical Assistance also known as TMA from [redacted], 2018.

26. The Appellant and his wife incorrectly received TMA healthcare coverage for eleven months.

27. The Appellant's child received Medicaid Husky A – Children from [redacted] 2017 through [redacted] 2018.

28. AHCT correctly determined that the Appellant, his wife, and their minor child were over the income limit for the Medicaid Husky A coverage.

29. AHCT correctly granted TMA coverage for the Appellant's child effective [redacted] 2018.

30. AHCT correctly determined that the Appellant and his wife were no longer eligible to receive 12 months of TMA coverage.

31. AHCT incorrectly discontinued the TMA effective [redacted] 2018, because the Appellant and his wife received eligibility under that healthcare coverage group for the duration of eleven months.

DISCUSSION

Medicaid Husky A for Parents and Caretakers eligibility is based on Modified Adjusted Gross Income. Based on the income reported by the Appellant at time of application, all members of the household are over income and therefore not eligible for the Husky A Program for Parents and Caretakers.

At the hearing the Appellant's wife reported that she has a 401K and she latter provided her pay stubs and the Appellant's pay stubs, unfortunately after her 401K contributions were applied the total household MAGI still over the income limit for Medicaid Husky A for a household of three.

The Appellant's wife also reported that she and her husband are paying medical bills and both have medical a condition. The Affordable Care Act and its supporting regulation is clear in regards to the MAGI allowable deductions and medical expenses or condition are not allowable deductions.

DECISION

The Appellant's appeal is **DENIED** in regards to the denial of Husky A- Parents and caregivers and discontinuance of the TMA coverage.

The Appellant's appeal is **GRANTED** in regards to the effective day of the TMA discontinuance.

ORDER

1. AHCT will reopen the TMA coverage for the Appellant and his wife for the month of [redacted] **2018** only.

2. Compliance with this order is due to the undersigned within 15 days of this order.

Veronica King

Veronica King
Hearing Officer

Pc: Amanda Maloney, Supervisor, AHCT
Cathy Davis, Appeals Coordinator, AHCT

Modified Adjusted Gross Income (MAGI) Medicaid and Children's Health Insurance Program (CHIP) Right to Request Reconsideration

For denials or reductions of MAGI Medicaid and CHIP, 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 Legal Counsel, Regulations, and Administrative Hearings, 55 Farmington Avenue, Hartford, CT 06105-3725.

Right to Appeal

For denials, terminations or reductions of MAGI Medicaid and CHIP eligibility, 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 his designee in accordance with§17b-61 of the Connecticut General Statutes. The Agency's decision to grant an extensions 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.