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

Case ID # [REDACTED]
Client ID # [REDACTED]
Request # [REDACTED]

NOTICE OF DECISION

PARTY

[REDACTED]

PROCEDURAL BACKGROUND

On [REDACTED], 2018, Access Health CT ("AHCT") sent [REDACTED] (the "Appellant") a notice of action discontinuing her Medicaid benefits under the Husky A Extended Medical Assistance Program ("X03") effective [REDACTED], 2018.

On [REDACTED], 2018, the Appellant requested an administrative hearing to contest the Department's action to discontinue such benefits.

On [REDACTED], 2018, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for May 4, 2018.

On [REDACTED], OLCRAH, at the Appellant's request, issued a notice rescheduling the administrative hearing for [REDACTED] 2018.

On [REDACTED], 2018, in accordance with sections 17b-60, 17b-61 and 4-176e to 4-189, inclusive, of the Connecticut General Statutes, Title 45 Code of Federal Regulations ("CFR") §155.505(b) and §155.510 and/or 42 CFR §457.113, OLCRAH held an administrative hearing by telephone.

The following individuals called in for the hearing:
[REDACTED], Appellant
Krystal Sherman-Davis, AHCT Representative
Christopher Turner, Hearing Officer

STATEMENT OF THE ISSUES

The first issue to be decided is whether AHCT's decision to discontinue the Appellant's X03 Medicaid assistance effective ████, 2018 was correct.

The second issue to be decided is whether AHCT's decision to deny the Appellant's request for Husky A for Parents/Caretakers ("X07") Medicaid assistance due to having income in excess of the program limit was correct.

FINDINGS OF FACT

1. On ████, 2018, AHCT received the Appellant's Husky renewal application. (Exhibit 1: Application dated ██/18; Hearing summary)

2. On ████, 2018, AHCT processed the Appellant's Husky renewal. (Hearing summary)

3. On ████, 2018, AHCT sent the Appellant an Eligibility Determination notice. The notice indicated in relevant part, "You (████) no longer qualify for Husky A – Transitional Medical Assistance because the maximum coverage period is 12 months." The Appellant was found eligible for a premium tax credit of $372.00 monthly. The Appellant's son was found eligible for Husky B. (Exhibit 3: Notice dated ██/18)

4. The Appellant received X03 for herself and son for the period of ██/17 through ██/18. (Exhibit 2: Eligibility determination; Record)

5. The Appellant's X03 is active pending the outcome of the fair hearing. (Testimony)

6. The Appellant is awaiting an eligibility determination for her S05 application. (Appellant's testimony)

7. The Appellant works full-time and earns a weekly salary of $520.00 or $2,236.00 monthly. (Appellant's Exhibit C: Paystubs)

8. The Federal Poverty Level ("FPL") for an assistance unit of two for 2018 is $1,372.00 monthly. (Federal Register/Volume 83, FR 2642)

9. The monthly income limit for an assistance unit of two applying for or receiving Husky A for Parents/Caretakers is $1,893.00 monthly. (Record; Hearing summary)

CONCLUSIONS OF LAW

1. Section 17b-260 of the Connecticut General Statutes ("CGS") authorizes 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. Title 45 of the 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) or this section that is designated by the Exchange, if the Exchange establishes an appeals process in accordance with the requirements of this subpart.

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

3. Title 45 of the 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.

4. CGS §17b-261 (f) provides, 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.

CGS § 17b-264 provides that 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.

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

UPM § 2540.09 (A) (2) provides that the assistance unit is not required to pass any income or asset tests during the twelve month period of eligibility for X03 Medical Assistance.

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 X07.

UPM § 2540.09 (B) (3) provides that Extended Medical Assistance benefits may end prior to the end of the twelve-month period of eligibility under the following circumstances:

a. the assistance unit moves out of state; or
b. all members of the assistance unit expire; or
c. there is no longer a child in the home under 19 years of age; or
d. the assistance unit applies for and is found eligible for another Medicaid coverage group.

The Department correctly discontinued the Appellant's X03 effective ██████, 2018, as the Appellant received twelve months of coverage.

5. Title 26 of the CFR § 1.36B-1(e)(1) provides in general, household income is the sum of-
   (i) A taxpayer's modified adjusted gross income ("MAGI") (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.

6. Title 42 of the CFR §435.603 (d) (4) provides effective January 1, 2014, in determining the eligibility of an individual using MAGI-based income, 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 in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.

   Title 42 of the 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 expenses are excluded from income.
   (3) American Indian/Alaska Native exceptions.

7. Public Act 17-2, Section 138, June 2017 Special Session provides in part that except as provided in section 17b-277 and section 17b-292, the medical assistance program shall provide coverage 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 thirty-three per cent of the federal poverty level without an asset limit.

8. One hundred thirty-three percent of the FPL for a household of two in █████ 2018 for a parent or caretaker relative totaled $1,824.76 (($1,372.00 FPL x 1.33) rounded to $1,824.00).

9. Five percent of the FPL for two equals $68.60 ($1,372.00 x 0.05).

10. The Appellant's applicable MAGI totaled $2,167.00 ($2,236.00 - $68.60 (rounded to the nearest dollar)) per month.

    AHCT correctly determined the Appellant's MAGI of $2,167.00 exceeded the household of two $1,824.00 monthly income limit for Parents and Caretakers.

DECISION

The Appellant's appeal is denied.

Christopher Turner
Hearing Officer

Cc: Becky Brown, Health Insurance Exchange Access CT
Mike Towers, Health Insurance Exchange Access CT
Krystal Sherman-Davis, Health Insurance Exchange Access CT

APTC/CSR

Right to Appeal

For APTC or CSR eligibility determinations, the Appellant has the right to appeal to the United States Department of Health and Human Services (HHS) within 30 days of the date of this decision. To obtain an Appeal Request Form, go to https://www.healthcare.gov/can-i-appeal-a-marketplace-decision/ or call 1-800-318-2596 (TTY: 1-855-889-4325). HHS will let the Appellant know what it decides within 90 days of the appeal request. There is no right to judicial review of the decision by HHS.

There is no right to request reconsideration for denials or reductions of Advanced Primary Tax Credits (APTC) or Cost Sharing Reduction (CSR).

MEDICAID AND 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, 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 Department of Social Services, Director, Office of Legal Counsel, Regulations, and Administrative Hearings, 55 Farmington Avenue, Hartford, CT 06105.

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, 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, 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 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.