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 # 121796

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2018, the Department of Social Services ("Department") sent [redacted] (the "Appellant") a Notice of Action ("NOA") discontinuing her Medicaid/Husky D healthcare coverage, effective [redacted], 2018, because her household's income exceeded the income limit for the program.

On [redacted], 2018, the Appellant requested an administrative hearing to contest the Department's decision to discontinue her Medicaid/Husky D healthcare coverage.

On [redacted], 2018, the Office of Legal Counsel, Regulations, and Administrative hearings ("OLCRAH") issued a notice scheduling an administrative hearing for [redacted], 2018 @ 9:30 AM.

On [redacted] 2018, in accordance with sections 17b-60, 17b-264 and 4-176e to -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.
The following individuals participated in the hearing:

[redacted], Appellant
Guerline Dominique, Department's Representative
Miklos Mencseli, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether the Appellant is ineligible for healthcare coverage under the Medicaid/Husky D program, due to excess income.

FINDINGS OF FACT

1. The Appellant is [redacted] year old individual receiving Husky D Medical for a household of one. (Summary, Exhibit 2: ImpaCT Household Composition Printout, Record)

2. On [redacted] 2018, the Appellant submitted her SNAP/Cash/Medical renewal form. (Exhibit A: ImpaCT Case Notes)

3. On [redacted], 2018, the Department processed the Appellant's renewal. (Summary, Exhibit A)

4. The Appellant reported new employment on her renewal form. (Exhibit A)

5. The Department verified the Appellant's start date of [redacted] 2018 and her gross wages through the Work Number. (Summary, Exhibit A, Exhibit D: Work Number printout)

6. The Appellant received her first pay on [redacted], 2018. (Exhibit D)

7. The Department determined her gross monthly income as $2,471.68:
   - $687.59 [redacted]/18
   - $536.47 [redacted]/18
   - $537.70 [redacted]/18
   - $537.49 [redacted]/18

   equals $2,299.25 / 4 = $574.81 x 4.3 = $2,471.68

8. The Department determined that the Appellant's monthly income of $2,471.68 exceeded the income limit of $1,345.96 per month for the Medicaid/Husky D program for a household consisting of 1 member. (Summary, Exhibit A)

9. On [redacted], 2018, the Department sent the Appellant a notice stating she does not qualify for Husky D as her household income is over the income limit for her household size. (Exhibit E: NOA dated [redacted]-18)

10. The Appellant is employed by [redacted] [redacted]l as a cashier. (Record)

11. The Appellant's hours have been reduced as more staff has been hired. (Record)

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) (2) 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: the State Medicaid agency, or any other State agency that meets the qualification of paragraph (a) (1) of this section.

6. 45 CFR 155.410 (a) (1) (2) General requirements. Provides the Exchange must provide an initial open enrollment period and annual open enrollment periods consistent with this section, during which qualified individuals may enroll in a QHP and enrollees may change QHPs. The Exchange may only permit a qualified individual to enroll in a QHP or an enrollee to change QHPs during the initial open enrollment period specified in paragraph (b) of this section, the annual open enrolment period specified in paragraph (e) of this section, or a special enrollment period described in §155.420 of this subpart for which the qualified individual has been determined eligible.

7. 45 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.

8. State statute provides that Husky D or Medicaid Coverage for the Lowest Income Populations program means Medicaid provided to non-pregnant low-income adults who are age 18 to sixty-four, as authorized pursuant to section 17b-8. [Conn. Gen. Stats. § 17b-290(16)]

9. The Department correctly determined Husky D Medicaid as the appropriate medical coverage group for the Appellant.

10. 42 CFR § 435.119 provides for coverage for individual age 19 or older and under age 65 at or below 133 percent of the Federal Poverty Level ("FPL"). It provides in part:

    a. Basis. This section implements section 1902(a)(10)(A)(i)(VIII) of the Act.
    b. Eligibility. Effective January 1, 2014, the agency must provide Medicaid to individuals who:
        1. Are age 19 or older and under age 65;
        2. Are not pregnant;
        3. Are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act;
        4. Are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part; and
        5. Have household income that is at or below 133 percent FPL for the applicable family size.

11. 42 CFR § 435.603(b) defines family size as the number of persons counted as members of an individual's household. In the case of determining the family size of a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. In the case of determining the family size of other individual who have a pregnant woman in their household, the pregnant woman is counted, at State option, as either 1 or 2 person(s) or as herself plus the number of children she is expect to deliver.

12. 42 CFR 435.603(f)(1) provides for the basic rule for taxpayers not claimed as a tax dependent. In the case of an individual who expects to file a tax return for the taxable year in which an initial determination of renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of the taxpayer and, subject to paragraph (f)(5) of this section, all persons who such individual expects to claim as a tax dependent.

13. The Department correctly determined the Appellant is a household of one.

14. Effective March 1, 2018, the FPL for a household of one is $1,012.00 per month. ($12,144.00 per year / 12 months = $1,012.00 per month) [Federal Register, Vol.

82, No. 19, January 31, 2018, pp. 8831-8832]

15. The Medicaid income limit for a household of one is $1,345.96 for individuals age 19 or older and under age 65. ($1,012.00 x 133% = $1,345.96 per month)

16. 42 CFR 435.603(a)(2) provides that effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individual identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.

17. 42 CFR § 435.603(c) provides that except as specified in paragraph (i), (j), and (k) and (k) of this section, the agency must determine financial eligibility for Medicaid based on "household income" as defined in paragraph (d) of this section.

18. 42 CFR § 435.603(d)(1) provides for household income. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household 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.

19. 42 CFR § 435.603(d)(4) provides that 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.

20. Five percent (5%) of the FPL for a household of one equals $50.60. ($1,012.00 x 5% = $50.60)

21. 42 CFR § 435.603(e) provides for MAGI-based income. For the purposes of this section, 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:

    a. An amount received as a lump sum is counted as income only in the month received.
    b. Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded from income.
    c. Provides for American Indian/Alaska Native exceptions.

22. United States Code ("U.S.C.") § 36B(d)(2)(B) 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.

23. Uniform Policy Manual ("UPM") § 5025.05 B provides that 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:

    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;

24. The Department correctly determined the Appellant's gross countable monthly income as $2,471.68 ($574.81per week average x 4.3 weeks).

25. The Appellant's MAGI equals $2,421.08 per month ($2,471.68 monthly income; minus $50.60, 5% of the FPL for 1).

26. The Appellant's monthly countable MAGI of $2,421.08 exceeds the income limit for the Medicaid/Husky D program for a household consisting of one member of $1,345.96

27. The Department correctly determined that the Appellant's MAGI income exceeds the income limit for the Medicaid/Husky D program.

DECISION

The Appellant's appeal is Denied

Miklos J. Mencseli
Fair Hearings Officer

C: Musa Mohamud, Operations Manager, DO#10 Hartford

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.