STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT06105-3725

[redacted] 2018
Signature Confirmation

Client ID # [redacted]
Request # [redacted]

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2018, the Health Insurance Exchange Access Health CT ("AHCT") issued [redacted] ("the Appellant") a Notice of Action explaining that her HUSKY D Medicaid for Low Income Adults ("MLIA") assistance for herself, [redacted] and [redacted] would be discontinued effective [redacted], 2018.

On [redacted], 2018, the Appellant requested an administrative hearing to contest the Department's decision to discontinue Medicaid benefits.

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

On [redacted], 2018, in accordance with Connecticut General Statutes § 17b-60, 17b-61 and 4-176e to 4-184, inclusive, the Department held an administrative hearing. The following individuals were present at the hearing:

[redacted], the Appellant
Debra Henry, Appeals Coordinator, Access Health CT representative
Roberta Gould, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department correctly discontinued the Appellant's Husky D Medicaid assistance for herself and her children.

FINDINGS OF FACT

1. The Appellant received Husky D Medicaid assistance for herself and for her children, [redacted] (D.O.B. [redacted]) and [redacted] (D.O.B. [redacted]). (Exhibit 1: Application information and Hearing summary)

2. The Appellant lives in [redacted], CT. (Hearing record and Appellant's testimony)

3. On [redacted], 2017, AHCT received a Husky change report for the Appellant. (Exhibit 1 and Hearing summary)

4. On [redacted], 2017, the Appellant self-declared Unemployment Compensation Benefits ("UCB") of $613.00 gross per week, or $2,635.90 gross per month ($613.00 x 4.3). (Exhibit 1 and Hearing summary)

5. On [redacted] 2018, AHCT sent the Appellant a notice advising her that she, [redacted] and [redacted] do not qualify for Husky D Medicaid assistance because her monthly income is over the income limit for this program for a household of three people. (Exhibit 3: Notice of updated health care dated [redacted]2018 and Hearing summary)

6. On [redacted] 2018, AHCT discontinued the Appellant's Husky D Medicaid assistance effective [redacted], 2018. (Exhibit 3 and Hearing summary)

CONCLUSIONS OF LAW

1. Uniform Policy Manual ("UPM") § 5500.01 provides that a needs group is the group of persons comprising the assistance unit and certain other persons whose basic needs are added to the total needs of the assistance unit members when determining the income eligibility of the assistance unit.

2. AHCT correctly determined that the Appellant is a needs group of three persons.

4. Uniform Policy Manual ("UPM") § 4510.10(B) provides that [redacted], CT is part of Region B.

5. AHCT correctly determined that the Appellant resides in Region B.

6. Federal Medicaid law requires the Department to use income limits based on the Federal Poverty Level ("FPL") for the Husky D Medicaid program. 42 United States

Code ("U.S.C.") § 1396a (a)(10)(A)(i)(VIII); 42 U.S.C. § 1396(a)(k)(2).

7. The income standard applicable to the Husky D Medicaid program for individuals residing in Region B is 138% of the FPL. Connecticut Medicaid State Plan amendment (effective March 1, 2015)

8. Effective March 1, 2017, the monthly FPL for three person is $1,702.00. (Federal Register, Vol. 82, No. 19, January 31, 2017)

9. The Husky D income standard for a three person household in Region B is $2,348.76 ($1,702.00 FPL x 138%).

10. AHCT correctly determined the income standard for the Appellant's assistance unit of Three is $2,348.76.

11. UPM § 5005 provides that in consideration of income, the Department counts the assistance unit's available income, except to the extent that it is specifically excluded. Income is considered available if it is:

    1. Received directly by the assistance unit; or

    2. Received by someone else on behalf of the assistance unit and the unit fails to prove that it is inaccessible; or

    3. Deemed by the Department to benefit the assistance unit.

12. UPM § 5025.05(B)(2) 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:

    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;

13. The Department correctly determined that the Appellant's total gross monthly UCB income at the time of her change report was $2,635.90 ($613.00 x 4.3).

14. The Department correctly determined that the Appellant's applied income exceeded the monthly income standard of $2,348.76.

15. The Department correctly determined that the Appellant's income exceeded the income standard for the Husky D Medicaid program.

16. On [redacted] 2018, the Department correctly discontinued the Appellant's Husky D Medicaid assistance for herself and her children effective [redacted] 2018, because her gross monthly UCB income exceeded the income standard.

DECISION

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

Roberta Gould
Hearing Officer

Cc: Amanda Maloney, Health Insurance Exchange Access Health CT

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 06105-3725.

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, CT06106 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.