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

[redacted] **2019**
Signature Confirmation

CLIENT No # [redacted]
Request # 143999

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2019, the Health Insurance Exchange Access Health CT- ("AHCT") sent [redacted] (the "Appellant") a Notice of Action ("NOA") denying the Appellant's Medicaid Husky A, Parent and Caretakers Medicaid healthcare coverage.

On [redacted] 2019, the Appellant requested an administrative hearing to contest the decision to deny Medicaid A Parent and Caretakers Husky benefits.

On [redacted] 2019, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2019.

On [redacted] 2019, the Appellant requested a re-schedule of the administrative hearing and it was granted.

On [redacted] 2019, OLCRAH issued a notice scheduling the administrative hearing for [redacted], 2019.

On [redacted] 2019, in accordance with sections 17b-60, 17b-264 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 were present at the hearing:

[redacted], Appellant
Cathy A. Davis, AHCT Representative
Almelinda McLeod, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether the Departments' action to discontinue the Husky A, Parents and Caretakers Medicaid coverage was correct in accordance with the regulations.

FINDINGS OF FACT

1. On [redacted] 2016, the Appellant had an organ transplant where services for transplant services were covered under Medicare T and her health insurance from her employer became her secondary insurance. (Appellants' testimony)

2. Medicare T is specifically for transplant and transplant-related services which include the transplant itself, follow up every 3 months for appointments and anti-rejection medications. The Appellant needs secondary insurance. (Appellant's testimony)

3. In [redacted] 2016, the Appellant returned to work, her medical insurance from her employer changed and became too expensive for her to keep. (Appellant's testimony)

4. Sometime in 2016, the Appellant became active on Medicaid Husky A Parents and Caretakers for a household of 3 that consisted of herself and two children. The Appellant was simultaneously active Husky A Medicaid and receiving Medicare T for the transplant services. (Hearing record)

5. Sometime in [redacted] 2019, the Appellant called AHCT to report that her older daughter moved out of her home and was no longer contributing to the household. The Appellant's household changed from a household of three to a household of two. (Appellant's testimony)

6. At this time, the Appellant updated her case and self-declared her household income as $2239.00 per month because she did not have paystubs to submit as verification. (Appellant testimony)

7. Sometime in [redacted]2019, the Appellant received a request from the Department to verify her wages. (Hearing record)

8. Sometime in [redacted] 2019, the Department received the following bi-weekly wage stubs from the Appellant:
   - [redacted]/19 – gross income of $ 1143.25 (Includes OT & Holiday pay)
   - [redacted]/19 – gross income of $1013.20 (Exhibit 4- paystubs)

9. The households' average gross income based on the wage stubs provided was $ 2318.19. [$1143.25 + $1013.20 = $2156.45/ 2= $1078.23 x 2.15= $2318.19]

10. The income limit for the Husky A Parent and Caretakers for a household of two is $2184.00. (Exhibit 3, NOA)

11. On [redacted] 2019, the Department discontinued the Appellant's Husky A Parent and Caretaker's Medicaid because the self-attested household's income of $2239.00 exceeded the income limit and because she is enrolled in a Medicare program, she does not qualify to enroll in a Qualified Health Plan for 2019. (Exhibit 3)

12. The Federal poverty Limit ("FPL") for a family of two at the time of enrollment was $16,910 per year which converted equals $1410.00 ($16,910 /12) per month. (Federal Register)

13. AHCT explains that the system is reading that the Appellant has Medicare but does not distinguish whether it is the traditional Medicare Part A and Part B or transplant services under the Medicare T. As a result, the system does not allow for a Transitional Medical Assistance ("TMA") determination. (Department testimony)

14. As of the date of this hearing, the Appellant's case has been referred to the Escalations Unit to determine TMA eligibility for the Appellant based on losing Husky A due to excess income. The case is currently pending results. (Department testimony)

15. The issuance of this decision is timely under Connecticut General Statute 17b-61 (a), which requires that a decision be issued within 90 days of the request for an administrative hearing. The Appellant requested an administrative hearing on [redacted], 2019. Therefore, this decision is due no later than [redacted] 2019. However, the Appellant requested to reschedule the administrative hearing extending to [redacted], 2019. Because of this [redacted] day delay in the closing of the hearing record, this final decision was not due until [redacted], 2019, and is therefore timely.

CONCLUSIONS OF LAW

1. Section 17b-260 of the Connecticut General Statutes ("Conn. Gen. Stats.") 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 Conn. Gen. Stats 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 Code of Federal Regulations ("CFR") § 155.110 (A) (2) provides the State may elect to authorize an Exchange established by the State to enter into an agreement with an eligible entity to carry out or more responsibilities of the Exchange. An eligible entity is the State Medicaid agency or any other State agency that meets the qualifications of paragraph (a) (1) of this section.

4. 45 CFR §155.505 (c) (1) provides Options for Exchange appeals. 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; or

5. 45 CFR §155.505 (d) Eligible entities. An appeals process established under this subpart must comply with § 155.110 (a).

6. 42 CFR § 435.603(f) (1) (2) (iii) (3) (iii) provides for the construction of the modified adjusted gross income ("MAGI") household.

7. 42 CFR § 435.603 (d) (1) provides for the construction of the modified adjusted gross income ("MAGI") household. Household income – (1) General Rule. 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 in the individual's household.

8. The Appellants' MAGI household consist of herself and one child. She is a household of two.

9. 42 CFR §435.603(d) 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, 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.

10. Five percent of the FPL for a family of two is $845.50 ($16,910 x. 05) per year which converted to $70.46 ($845.50 /12) per month.

11. The Appellant's household countable MAGI for a household of two based on the reported income at the time of application was $2168.54 ($2239.00 -$70.46) per month.

12. 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.

13. Public Act 15-5 June Sp. Session 370 (a) provides in part Except as provided 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 program shall provide coverage to persons under the age of nineteen with household income up to one hundred ninety–six percent 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 percent 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 percent of the federal poverty level without an asset limit.

14. One hundred fifty percent of the FPL for a household of two is $2115.00 ($1410.00 x 1.50) per month.

15. **The Appellant's household countable MAGI household income of $2168.54 per month exceeds the income threshold of $2115.00 (150% FPL) for Medicaid / Husky A for Parents and Caretakers for a household of two.**

16. **The Department correctly determined the Appellant is over income for the Medicaid Husky A for Parents and Caretakers.**

17. **The Department correctly discontinued the Appellant the Husky A, Parents & Caretakers medical coverage for the Appellant**.

18. CGS § 17b-261(f) provides that 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 [redacted] 2005, shall receive the balance of such extended benefits, provided no such family shall receive more than twelve additional months of such benefits.

19. 42 CFR § 119 (c) (1) provides a State may not provide Medicaid under this section to a parent or other caretaker relative living with a dependent child if the child is under the age specified in paragraph (c) (2) of this section, unless such child is receiving benefits under Medicaid, the Children's Health Insurance Program ("CHIP") under subchapter D of this chapter, or otherwise is enrolled in minimum essential coverage as defined in § 435.4 of this part.

20. **The Department incorrectly determined that the Appellant was not eligible for TMA when the Husky A was discontinued due to excess income. Statutes state that the Appellant's medical should be extended one year because she lost Husky A Parents and Caretakers due to excess income**.

21. 26 CFR. §1.5000A-2 (b) (1) (i) provides that Medicare in Government–sponsored program is Minimum essential coverage.

22. 26 CFR § 1.5000 A-2 (b) (2) provides, in part, that certain health care coverage are not minimum essential coverage under a Government-sponsored program.

23. 26 CFR § 1.5000A-2 (g) pertains to excepted benefits and provides that minimum essential coverage does not include any coverage that consists solely of excepted benefits described in section 2791 (c) (1) through (c) (4) of the Public Health Services Act [42 U.S.C. 300gg-91 (c)].

24. 42 United States Code ("U.S.C."). § 300gg-91 (c) (3) (A) pertains to excepted benefits and provides that benefits not subject to requirements if offered as independent, non-coordinated benefits are covered only for a specified disease or illness.

25. **AHCT incorrectly determined Medicare T was minimum essential coverage because coverage for the transplant, limited to the transplant itself and all related transplant services, are covered for a specified disease or illness and therefore considered excepted benefits.**

DISCUSSION

The Appellants' income exceeded the income limit for Husky A Parents and Caretakers and lost her medical coverage under this program. Usually, when an individual had been active in this program, there would be eligibility for a Transitional Medical Assistance ("TMA") program, which extends the medical coverage for one year. In this case, however, the Departments' computer system indicated that the Appellants' transplant Medicare coverage as minimum essential coverage and would not allow a TMA grant.

42 U.S.C. § 300gg-91 (c) (3) (A) specifically states that an exception is made for a specified disease or illness. An organ transplant and transplant services are very specific in nature and in its treatment. The Appellant testified that her transplant and treatments thereafter were coverage limited to only the transplant and its related services; therefore falls under the category of excepted benefits permitted by federal law.

It also must be noted that the Appellant is not, otherwise eligible for Medicare due to age or disability, thus Medicare T is not minimum essential coverage. State statute dictates that to the extent permitted by federal law, Medicaid eligibility shall be extended for one year. Based on the regulations and the United States Code, the Appellant is eligible for the one-year TMA program.

DECISION

The Appellant's appeal is GRANTED.

ORDER

1. The Department shall grant TMA effective [redacted] 2019, for a period of one year.

2. Compliance with this order shall be given to the undersigned by [redacted], 2019.

Almelinda McLeod
Hearing Officer

CC: Becky.Brown@conduent.com
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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.