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

[redacted] **2024**
Signature Confirmation

[redacted]
[redacted]
Hearing # 235318

NOTICE OF DECISION

PARTY

[redacted]
[redacted]
[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2024, the Health Insurance Exchange Access Health CT ("AHCT") sent [redacted] (the "Appellant"), an Eligibility and Enrollment Notice of Action ("NOA") discontinuing her Medicaid/HUSKY A Transitional Medical Assistance ("TMA") healthcare coverage because the maximum coverage period is 12 months.

On [redacted] 2024, the Appellant requested a hearing to contest AHCT's discontinuance of the TMA.

On [redacted] 2024, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2024.

On [redacted] 2024, in accordance with sections 17b-60, 17b-264, and 4-176e to 4-189, inclusive, of the Connecticut General Statues ("Conn. Gen. Stat."), Title 45 of the Code of Federal Regulations ("C.F.R.") §§ 155.510 and/or Title 42 C.F.R. § 457.1130, OLCRAH held a telephonic administrative hearing. The following individuals participated in the hearing:

[redacted], Appellant
Debra Henry, AHCT Representative
Carla Hardy, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT correctly discontinued the TMA effective [redacted] 2024.

FINDINGS OF FACT

1. The Appellant's household consists of two members. They include the Appellant and her minor child. (Exhibit 2: Application, [redacted]24; Exhibit 3: Eligibility Determination; Appellant's Testimony)

2. The Appellant was granted TMA effective [redacted] 2023. (Exhibit 3: Eligibility Determination; Department's Testimony; Appellant's Testimony)

3. The Appellant was granted the TMA because her income exceeded the income limit for HUSKY A. (Department's Testimony)

4. AHCT calculated the Appellant's income equals $4,424.61 monthly. (Exhibit 2: Application, [redacted]/24)

5. The Appellant states her monthly income ranges between $4,200.00 and $4,400.00. (Appellant's Testimony)

6. The Appellant's TMA healthcare coverage began [redacted] 2023. It will end on [redacted] 2024. (Exhibit 3, Department's Testimony)

7. The Appellant will receive 12 months of TMA coverage when it terminates on [redacted] 2024. (Fact 6)

8. The Appellant's child has TMA coverage that will end on [redacted] 2024. (Exhibit 4: NOA, [redacted]24)

9. The Federal Poverty Limit ("FPL") for a two-person household is $1,255.00 monthly. (Federal Register)

10. The issuance of this decision is timely under Connecticut General Statutes § 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] 2024. Therefore, this decision is due no later than [redacted] 2024. (Hearing Record)

CONCLUSIONS OF LAW

1. Conn. Gen. Stat. Section 17b-260 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. Conn. Gen. Stat. § 17b-264 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 C.F.R. § 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. Title 45 C.F.R. § 155.505(d) provides that an appeals process established under this subpart must comply with § 155.110(a).

5. Title 45 C.F.R. § 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. Title 42 of the United States Code (“U.S.C.”) § 1396r-6(a)(1)(A) provides, “Notwithstanding any other provision of this subchapter but subject to subparagraph (B) and paragraph (5), each State plan approved under this subchapter must provide that each family which was receiving aid pursuant to a

plan of the State approved under part A of subchapter IV in at least 3 of the 6 months immediately preceding the month in which such family becomes ineligible for such aid, because of hours of, or income from, employment of the caretaker relative (as defined in subsection (e)) or because of section 602(a)(8)(B)(ii)(II) of this title (providing for a time-limited earned income disregard), shall, subject to paragraph (3) and without any reapplication for benefits under the plan, remain eligible for assistance under the plan approved under this subchapter during the immediately succeeding 6-month period in accordance with this subsection."

Title 42 U.S.C. § 1396r-6(a)(5) provides that a State may elect to treat any reference in this subsection to a 6-month period (or 6 months) as a reference to a 12-month period (or 12 months)…

Conn. Gen. Stat. § 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 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.

The State of Connecticut elected to provide families with 12 months of extended healthcare coverage.

The Appellant received extended medical benefits from [redacted] 2023, through [redacted] 2024.

The Appellant received extended medical coverage for 12 months.

7. Conn. Gen. Stat. § 17b-261(a)(2) provides in relevant part that 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-five per cent of the federal poverty level without an asset limit.

One hundred and fifty-five percent of the FPL for a two-person household equals $1,945.25 ($1,255.00 x 155% = $1,945.25)

The Appellant's $4,424.61 income exceeds the $1,945.25 income limit for parents and needy caretaker relatives.

AHCT correctly determined that the Appellant received 12 months of TMA healthcare coverage between [redacted] 2023, through [redacted] 2024.

The Appellant received 12 months of TMA coverage, the maximum number of months permitted under state and federal law.

On [redacted] 2024, AHCT correctly discontinued the HUSKY A TMA effective [redacted] 2024, because the Appellant received the maximum 12 months of TMA, and her income exceeded the HUSKY A coverage for parents and caretakers.

DECISION

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

_____*Carla Hardy*_____
Carla Hardy
Hearing Officer

Pc: Becky Brown, Mike Towers, Debra Henry, AHCT

Advanced Premium Tax Credits (APTC) or Cost Sharing Reduction (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 APTC or CSR.

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, 165 Capitol Avenue, 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.