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

[redacted] **2016**
Signature Confirmation

CLIENT No # [redacted]
Request # 732405

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2015, the Health Insurance Exchange Access Health CT- ("AHCT") sent (the "Appellant") a Notice of Action ("NOA") denying the Appellant's Medicaid Husky D healthcare coverage.

On [redacted] 2015, the Appellant requested an administrative hearing to contest the decision to terminate such benefits.

On [redacted] 2015, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2016.

On [redacted] 2015, in accordance with sections 17b-60, 17-61 and 4-176e to 4-189 inclusive, of the Connecticut General Statutes, OLCRAH held an administrative hearing.

The following individuals were present at the hearing:

[redacted] Appellant
Judy Boucher, AHCT Representative
Almelinda McLeod, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether Health Insurance Exchange Access Health CT ("ACHT") correctly denied the Medicaid Husky D benefits.

FINDINGS OF FACT

1. On [redacted] 2015, the Appellant submitted an online change reporting application through the State of Connecticut Health Insurance Exchange. (Exhibit #1, Access Health Application #[redacted])

2. The Appellant applied for medical assistance as a household of one, single filing taxes, a United States Citizen and residing in [redacted]. (Exhibit #1, Access Health Application #[redacted]

3. The Appellant was 64 years old (DOB[redacted]/51) when she submitted the change report application. (Exhibit # 1 , Access Health Application)

4. As of [redacted] 2015, the Appellant testified that she is employed part time with [redacted], earns between $8.00 to $11.00 per hour (depending on the job) and works between 8 to 40 hours per week. (Appellant testimony)

5. On [redacted] 2015, the Appellant testified she reported a change to AHCT that she started to receive Social Security Retirement income effective [redacted] 2015. The Appellant testified that she did not have Medicare Part A because she was not 65 years of age. (Appellant's Testimony)

6. The Appellant testified that the household adjusted gross income in 2015 was approximately $22,000.00 and expects the adjusted gross income to be approximately $22,000 or less in 2016.(Exhibit #1, Application # [redacted] and Appellant testimony)

7. On [redacted] 2015, the Appellant received a NOA indicating the Appellant was eligible for a Qualified health plan that would begin on [redacted] 2015 and that the Appellant was denied Qualified Health Plan with Advanced Premium Tax credits and Medicaid because the Appellant was currently receiving Medicare. (Exhibit #2- Eligibility Determination Notice)

8. The Appellant testified that she called AHCT to clarify that she would not have Medicare Part A until she turned 65 in [redacted] 2016 and she wanted Medicaid for 2015. (Appellant testimony)

9. Medicare is considered “Minimum Essential Coverage”; any participant who is eligible for Medicare would not qualify for Medicaid or a Qualified Health Plan with a subsidy like the Applied Premium tax credit.

10. The denial notice did not indicate when the Husky D would terminate. (Exhibit #2, Change reporting Eligibility decision notice)

11. As of the date of this hearing, AHCT indicated the Appellant was active Husky D effective [redacted] 2014 and will continue to receive H/D benefits until [redacted] 2016. (AHCT testimony)

12. The Appellant became aware that she was active Husky D as of this hearing date. (Appellant’s testimony)

13. The Federal Poverty Limit for Husky D for one person is $1353.58.

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. 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.

3. 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

4. 45 CFR § 155.505 (d) Eligible entities. An appeals process established under this subpart must comply with § 155.110 (a).

5. 42 CFR § 435.119 (b) provides coverage for individuals age 19 or older and under age 65 at or below 133 percent FPL. 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.

6. Title 26 e-CFR § 1.5000A-2 (b) (i) (ii) pertains to Minimum essential coverage and provides in part: In general, Minimum essential coverage means coverage under a government–sponsored program. A Government –sponsored program means any of the following: Medicare. The Medicare program under part A of the Title XVIII of the Social Security Act (42 USC 1395c and following sections); and Medicaid. The Medicaid program under Title XIX of the Social Security Act (42 U.S.C. 1396 and following sections).

7. **The Appellant was 64 years of age when she reported she was eligible to receive Social Security Retirement income**.

8. **The Appellant would not turn 65 years of age until her birthday on [redacted] 2016, at which point she would then become eligible for the Medicare part A.**

9. **AHCT incorrectly determined that the Appellant was currently eligible for Medicare because she was not yet 65 years of age**.

10. 42 CFR § 435.930 (a) (b) provides that the agency must furnish Medicaid promptly to beneficiaries without delay caused by the agency's administrative procedures; continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible.

11. **AHCT testified the Appellant's Husky D Medicaid was never terminated and the Appellant was eligible for continuous Husky D eligibility from [redacted] 2014 to the present day of this hearing. The Husky D would become de-activated effective [redacted] 2016.**

12. 42 CFR § 431.210 pertains to the Content of notice. It provides A notice required under § 431.206 (c) (2), (c) (3), or (c)(4) of this subpart must contain- (a) A statement of what action the State , skilled nursing facility,

or nursing facility intends to take; (b) the Reasons for the intended action; (c) The specific regulations that support , or the change in Federal or State law that requires , the action; (d) An explanation of – (1) The individual's right to request an evidentiary hearing if one is available, or a State agency hearing (2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and (e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

13. Uniform Policy Manual ("UPM") 1555.25 (B) provides that assistance units are provided with notice of adverse action when a change in assistance unit circumstances results in ineligibility or reduced benefits, except when such notice is not required.

14. UPM 1570.10 (4) (c) provides in part, that in the Medicaid program, the Department sends adequate notice no later than the date of the action, under the following situation; the Department authorizes the assistance unit to receive assistance for a specific period of time and informs the unit in writing at the time of authorization that assistance automatically terminates when the specific period ends.

15. **AHCT correctly issued a Notice of Adverse action letter to the Appellant.**

16. **The notice issued by AHCT incorrectly stated the reason for the denial of the Husky D Medicaid as "Individual is currently receiving Medicare".**

17. **The notice issued by AHCT did not specify continued eligibility under the Husky D program for a specified period of time and did not inform the Appellant when the Husky D Medicaid would terminate automatically**.

DISCUSSION

The AHCT notice issued in [redacted] 2015 indicated that the Appellant was ineligible for a Medicaid because she was currently receiving Medicare. The Appellant testified she called to report she started to receive the Social Security retirement income in [redacted] 2015 but would not get Medicare Part A until she turned 65 years of age on [redacted] 2016. AHCT testified that the change reporting application was to determine her eligibility effective [redacted] 2016 and acknowledged that the letter did not specify Medicaid eligibility until the end of [redacted] 2016.

There is no question that the AHCT notice was deficient as it failed to display all the pertinent information regarding Husky D eligibility in a clear and accurate manner. The notice did not provide the Appellant with Husky D eligibility information for 2015 and did not specify that the Appellant was active Husky D until [redacted] 2016. As a result, the Appellant assumed that she did not have Medicaid coverage for 2015, which may have caused the Appellant an unnecessary hardship. However, I cannot make a ruling on the discontinuance of Husky D Medicaid because; the Appellant was continuously active on Husky D since August 2014 and continues to be eligible until [redacted] 2016.

DECISION

The Appellant's appeal is moot.

Almelinda McLeod
Hearing Officer

CC: Judith Boucher, AHCT Appeals Coordinator, Supervisor
Debra Henry, AHCT Appeals Coordinator

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 Legal Counsel, Regulations, and Administrative Hearings, 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 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.