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

[redacted] **2017**
Signature Confirmation

Client ID # [redacted]
Application # [redacted]
Hearing Request # 814926

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2017, the Health Insurance Exchange Access Health CT ("AHCT") sent [redacted] (the "Appellant") a notice discontinuing his HUSKY D Medicaid due to his refusal to agree to the terms and conditions of the Assignment of Interest.

On [redacted] 2017, The Appellant requested a hearing to contest AHCT's discontinuance of his Medicaid benefits.

On [redacted] 2017, the Office of legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2017.

On [redacted] 2017, in accordance with sections 17b-60, 17b-264 and 4-176e to 4-189, inclusive, of the Connecticut General Statutes, chapter 45 Code of Federal Regulations ("CFR") §§ 155.505(b) and 155.510 and/or 42 CFR § 457.1130, OLCRAH held an administrative hearing. The following individuals were present at the hearing:

[redacted] Appellant, via telephone
Rita Baboolal, AHCT Representative, via telephone
James Hinckley, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT was correct when it discontinued the Appellant's HUSKY D Medicaid.

FINDINGS OF FACT

1. The Appellant's household includes himself only. (Hearing Record, Appellant testimony)

2. On [redacted] 2017 the Appellant submitted an online renewal application for healthcare assistance. (Ex. 1: Application Information).

3. The online application asks applicants to answer "Yes" or "No" as to whether they agree to the terms and conditions of the Assignment of Interest, which are as follows:

   "I know that if Medicaid pays for a medical expense any money I get from other health insurance or legal settlements will go to Medicaid in an amount equal to what Medicaid pays for the expense. I know I'll be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and won't have to cooperate. I understand that AccessHealthCT.com will use data from my tax return during the renewal process to determine yearly eligibility for help paying for health insurance for the next 5 years. I know that I must tell the program that I'm enrolled in if information I listed on this application changes. I'm signing this application under penalty of perjury. This means I've provided true answers to all the questions on this form to the best of my knowledge. I know that if I'm not truthful, there may be a penalty".
   (Hearing Summary)

4. The Appellant answered the question on the online application, "No", that he did not accept the terms and conditions of the Assignment of Interest. (Ex. 1)

5. The Appellant intended to answer "No" on the application, and intended his answer to reflect that he was unwilling to accept the terms and conditions of the Assignment of Interest, because he does not agree with said terms and conditions. (Appellant testimony).

6. The Appellant is not applying for medical coverage for any dependent children, and is not making any good cause claim to not pursue medical support from an absent parent. (Hearing Record)

7. On [redacted] 2017, AHCT sent the Appellant a NOA advising him of his application results, and notifying him that his HUSKY benefits would end effective [redacted] 2017, and that the reason he did not qualify was because he did not agree to the terms and conditions of the Assignment of Interest. (Ex. 2: "Here are the Results of your Health Care Renewal" notice dated [redacted] 2017)

CONCLUSIONS OF LAW

1. Section 17b-260 of the Connecticut General Statutes ("Conn. Gen. Stat.") 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. Sec. 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 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. 42 CFR §435.610 provides that:

(a) as a condition of eligibility, the agency must require legally able applicants and recipients to:
(1) Assign rights to the Medicaid agency to medical support and to payment for medical care from any third party;
(2) Cooperate with the agency in establishing paternity and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating, and except for individuals described in section 1902(1)(1)(A) of the Act (poverty level pregnant women), who are exempt from cooperating in establishing paternity and obtaining medical support and payments from, or derived from, the father of the child born out of wedlock; and
(3) Cooperate in identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating.
(b) The requirements for assignment of rights must be applied uniformly for all groups covered under the plan.
(c) The requirements of paragraph (a) of this section for the assignment of rights to medical support and other payments and cooperation in obtaining medical support and payments are effective for medical assistance furnished on or after October 1, 1984. The requirement for cooperation in identifying and providing information for pursuing liable third parties is effective for medical assistance furnished on or after July 1, 1988.

7. Conn. Gen. Stat. § 17b-265(b) provides that an applicant or recipient or legally liable relative, by the act of the applicant's or recipient's receiving medical assistance, shall be deemed to have made a subrogation assignment and an assignment of claim for benefits to the department. The department shall inform an applicant of such assignments at the time of application. Any entitlements from a contractual agreement with an applicant or recipient, legally liable relative or a state or federal program for such medical services, not to exceed the amount expended by the department, shall be so assigned. Such entitlements shall be directly reimbursable to the department by third party payors. The Department of Social Services may assign its right to subrogation or its entitlement to benefits to a designee or a health care provider participating in the Medicaid program and providing services to an applicant or recipient, in order to assist the provider in obtaining payment for such services. In accordance with subsection (b) of section 38a-472, a provider that has received an assignment from the department shall notify the recipient's health insurer or other legally liable third party including, but not limited to, a self-insured plan, group health plan, as defined in Section 607(l) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, health care center, pharmacy benefit manager, dental benefit manager, third-party administrator or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, of the assignment upon rendition of services to the applicant or recipient. Failure to so notify the health insurer or other legally liable third party shall render the provider ineligible for

payment from the department. The provider shall notify the department of any request by the applicant or recipient or legally liable relative or representative of such applicant or recipient for billing information. This subsection shall not be construed to affect the right of an applicant or recipient to maintain an independent cause of action against such third party tortfeasor.

8. Assignment of rights to benefits is a condition of eligibility for the Medicaid program, and the Appellant is ineligible for medical assistance if he declines to agree to such assignment.

9. AHCT was correct when, on [redacted] 2017, it discontinued the Appellant's HUSKY D Medicaid effective [redacted] 2017, because the Appellant indicated that he was unwilling to accept the terms and conditions of the Assignment of Interest.

DISCUSSION

Federal Medicaid regulations provide that State agencies must require applicants to assign rights to benefits as a condition of eligibility, and state statute provides that such assignment shall be deemed to have been made by the act of receiving medical assistance. In essence, a refusal to agree to the terms of such assignment is the same as making a request for the Department to discontinue Medicaid benefits. The Appellant cannot relieve himself of the assignment requirements merely by refusing to sign that he agrees to them. By simply accepting Medicaid assistance, he binds himself to the terms. So when the Appellant made it clearly and unambiguously known that he was no longer willing to accept the terms and conditions of the Assignment of Interest, the Department took the correct action by discontinuing his case.

DECISION

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

James Hinckley
Hearing Officer

cc: Judy Boucher, Access Health CT

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

MEDICAID AND 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.

There is no right to request reconsideration for denials or reductions of Advanced Premium Tax Credits (APTC) or Cost Sharing Reduction (CSR).

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 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.