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

Signature Confirmation

Client ID #
Hearing Request #

NOTICE OF DECISION

PARTY

PROCEDURAL BACKGROUND

On , the Health Insurance Exchange Access Health CT ("AHCT") issued a Notice of Action ("NOA") to (the "Appellant") advising him that he was no longer eligible for Medicaid/HUSKY D healthcare coverage.

On , the Appellant requested an administrative hearing to contest the discontinuance of Medicaid/HUSKY D.

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

On 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 § 457.1130, OLCRAH held an administrative hearing by telephone. The following individuals participated in the hearing:

, Appellant
Sabrina Solis, AHCT Grievance and Appeals Representative
Alex, Interpreter # 8320 with United Language Group

Maureen Foley-Roy, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether Health Insurance Exchange Access Health CT ("AHCT") correctly discontinued the Medicaid/HUSKY D healthcare coverage.

FINDINGS OF FACT

1. The Appellant was a recipient of Medicaid/HUSKY D healthcare benefits prior to [redacted]. (Exhibit 3: Enrollment Details)

2. On [redacted] [redacted] [redacted], a change was reported through the Health Insurance Exchange system. The application filed indicated that the Appellant was now a recipient of Medicare. (Exhibit 4: Application Information)

3. On [redacted], AHCT sent the Appellant a notice advising that he was no longer eligible for HUSKY D Medicaid because he was receiving Medicare. The notice stated that if an individual was disabled, he could visit the connect.gov web site to see if he/she qualified for another Medicaid coverage group. (Exhibit 1: Health Care Coverage Renewal Decision Notice)

4. The Appellant wants to continue with HUSKY D benefits as well as Medicare because Medicare does not cover meet 100% of his medical needs. (Appellant's testimony and hearing request)

5. The Appellant did not explore other Medicaid coverage groups via the web site as suggested on the notice he received. (Appellant's testimony)

6. There is a HUSKY C Medicaid coverage group which assists disabled individuals who receive Medicaid. It is not administered by AHCT. The Appellant would have to go to the Department of Social Services website or into one of the Department's regional offices to explore eligibility for that program. (AHCT representative's testimony)

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. Section 17b-264 of the CGS 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) 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. 42 CFR § 435.119 provides that Medicaid health coverage is available for individuals age 19 or older and under age 65 at or below 133 percent of the Federal Poverty Limit ("FPL").

   (b). 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 the title XVIII of the Act** (Emphasis added)
   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.

AHCT correctly determined that the Appellant is a recipient of Medicare and therefore is ineligible for Medicaid/HUSKY D through AHCT.

AHCT correctly discontinued the Appellant's Medicaid/HUSKY D health coverage because he is a recipient of Medicare and has other options for Medicaid.

DISCUSSION

The regulations are clear that the Appellant is ineligible for Medicaid/HUSKY D because he is enrolled in Medicare. There are other Medicaid options for the Appellant, which were noted both at the hearing and in the notice that AHCT sent to the Appellant.

DECISION

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

Maureen Foley-Roy
Hearing Officer

Pc: Becky Brown, AHCT
Mike Towers, AHCT
Sabrina Solis, Appeals Coordinator, AHCT

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.