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

2022
Signature Confirmation

Case ID:
Client ID:
Request #: 191224

NOTICE OF DECISION

PARTY

PROCEDURAL BACKGROUND

On 2022, the Health Insurance Exchange, Access Health CT ("AHCT"), sent (the "Appellant") a Notice of Action ("NOA) discontinuing his Medicaid coverage under the Husky D program ("Husky D") effective , 2022.

On , 2022, the Appellant requested an administrative hearing to contest the AHCT's decision to discontinue such benefits.

On 2022, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for 2022.

On 2022, the Appellant requested a continuance which OLCRAH granted.

On , 2022, the OLCRAH issued a notice scheduling the administrative hearing for , 2022.

On 2022, 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 called in for the hearing:

█████████, Appellant
Debra Henry, AHCT Representative
Lisa Nyren, Fair Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT discontinuance of the Appellant's Medicaid coverage under the Husky D program effective █████ 2022 was correct.

FINDINGS OF FACT

1. The Appellant is █████ years old. (Hearing Record)

2. Beginning █████ 2018, the Appellant received Medicaid under the Husky D program for himself. (Hearing Record)

3. The Appellant receives hospitalization insurance coverage from the Social Security Administration under Medicare Part A effective █████ 2020. (Stipulated)

4. The Appellant receives medical insurance coverage from the Social Security Administration under Medicare Part B effective █████ 2020. (Stipulated)

5. The Appellant receives prescription coverage from the Social Security Administration under Medicare Part D effective █████ ██ 2020. (Stipulated)

6. Effective █████ 2020, the Appellant receives medical coverage under the Medicare Savings Program ("MSP") Qualified Medicare Beneficiary ("QMB") program as administered by the Department. (Stipulated)

7. Under the Families First Coronavirus Response Act ("FFCRA"), Connecticut maintained medical coverage under the Husky D program for active households during the public health emergency ("PHE") allowing the Appellant to retain his Husky D medical coverage in addition to his Medicare and MSP coverage. (Hearing Record)

8. On █████ 2020, the Centers for Medicaid and Medicare Services ("CMS") issued new regulations reinterpreting the continuous coverage rule

under the FFCRA allowing States to remove eligibility for continuous coverage due to the PHE to those individuals with medical coverage under the MSP. (Hearing Record)

9. An individual receiving Medicare benefits and benefits under the MSP does not qualify for extended medical coverage under the Husky D program during the PHE. (AHCT Representative's Testimony)

10. AHCT determined the Appellant ineligible for Husky D effective 2022 because the Appellant receives medical coverage under Medicare Parts A, B, and D and medical benefits under the MSP meeting the minimum essential coverage requirement. (Hearing Record)

11. On 2022, AHCT issued a notice to the Appellant. The notice stated the Appellant is not eligible for extended medical coverage under Husky D because he receives Medicare and MSP. (Exhibit 1: Notice of Action)

12. The Appellant received prior authorization for dental treatment while a beneficiary of Husky D. The dental treatment has not been completed and the Appellant seeks coverage under the Husky D program through the completion of the dental treatment. (Appellant's Testimony)

13. 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 , 2022. However, the hearing which was originally scheduled for 2022 was rescheduled to 2022 at the request of the Appellant causing a -day delay. Because this -day delay resulted from the Appellant's request, this decision is not due until 2022 and therefore timely.

CONCLUSIONS OF LAW

1. Section 17b-260 of the Connecticut State Statutes ("Conn. Gen. Stat.") provides as follows:

   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. State statute provides as follows:

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 to17b-262, inclusive, 17b-264 to 17b-285, inclusive, and 17b-357 to 17b-361, inclusive.

Conn. Gen. Stat. § 17b-264

3. Title 45 Section 115.110(a) of the Code of Federal Regulations ("C.F.R.") provides as follows:

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 coverages; and
2. The State Medicaid agency, or any other State agency that meets the qualifications of paragraph (a)(1) of this section.

AHCT is the State of Connecticut's health insurance exchange where consumers can enroll in affordable healthcare plans which include Husky D.

4. Federal regulation provides as follows:

Exchange eligibility appeals may be conducted by a State Exchange appeals entity or an eligible entity described in paragraph (d) or this section that is designated by the Exchange, if the Exchange establishes an appeals process in accordance with the requirements of this subpart.

45 C.F.R. § 155.505(c)(1)

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

5. Federal regulation provides as follows:

In general. Minimum essential coverage means coverage under a government-sponsored program (described in paragraph (b) of this section), an eligible employer-sponsored plan (described in paragraph (c) of this section), a plan in the individual market (described in paragraph (d) of this section), a grandfathered health plan (described in paragraph (e) of this section), or health benefits coverage (described in paragraph (f) of this section). Minimum essential coverage does not include coverage described in paragraph (g) of this section. All terms defined in this section apply for purposes of this section and § 1.5000A-1 and §§ 1.5000A-3 through 1.5000A-5.

26 C.F.R. § 1.5000A 2(a)

Federal regulation provides as follows:

Government-sponsored program - In general. Except as provided in paragraph (2), government-sponsored program means any of the following:

i. Medicare. The Medicare program under part A of Title XVIII of the Social Security Act (42 U.S.C. 1395c and following sections);
ii. Medicaid. The Medicaid program under Title XIX of the Social Security Act (42 U.S.C. 1396 and following sections);
iii. Children's Health Insurance Program. The Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act (42 U.S.C. 1397aa and following sections);
iv. TRICARE. Medical coverage under chapter 55 of Title 10, U.S.C., including coverage under the TRICARE program;
v. Veterans program. The following health care programs under chapter 17 or 18 of Title 38, U.S.C.;
    A. The medical benefits package authorized for eligible veterans under 38 U.S. CV. 1710 and 38 U.S.C. 1705;
    B. The civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) authorized under 38 U.S.C. 1781; and
    C. The comprehensive health care program authorized under 38 U.S.C. 1803 and 38 U.S. C. 1821 for certain children of Vietnam Veterans and Veterans of covered service in Korea who are suffering from spina bifida.
vi. Peace Corp program. A health plan under section 2504(e) of Title 22, U.S. C. (relating to Peace Corps volunteers); and
vii. Nonappropriated Fund Health Benefits Program. The Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Pub. L. 103-337; 10 U.S.C. 1587).

26 C.F.R. § 1.5000A 2(b)(1)

6. "This part sets forth, for the 50 states, the District of Columbia, the Northern

Mariana Islands, and American Samoa the mandatory and optional groups of individuals to whom Medicaid is provided under a State plan." 42 C.F.R. § 435.2(b)

Federal regulation provides as follows:

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.

42 C.F.R.§ 435.119(b)

Section 6008 of FAMILY FIRST CORONAVIRUS RESPONSE Act, 2020 provides for the Temporary Increase of Medicaid FMAP.

a. In General. Subject to subsection (b), for each calendar quarter occurring during the period beginning on the first day of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b–5(g)) and ending on the last day of the calendar quarter in which the last day of such emergency period occurs, the Federal medical assistance percentage determined for each State, including the District of Columbia, American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the United States Virgin Islands, under section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) shall be increased by 6.2 percentage points.
b. Requirement for all states. A State described in subsection (a) may not receive the increase described in such subsection in the Federal medical assistance percentage for such State, with respect to a quarter, if-

1. Eligibility standards, methodologies, or procedures under the State plan of such State under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (including any waiver under such title or section 1115 of such Act (42 U.S.C. 1315)) are more restrictive during such quarter than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on January 1, 2020
2. The amount of any premium imposed by the State pursuant to section 1916 or 1916A of such Act (42 U.S.C. 1396o, 1396o–1) during such quarter, with respect to an individual enrolled under such plan (or

waiver), exceeds the amount of such premium as of January 1, 2020

3. The State fails to provide that an individual who is enrolled for benefits under such plan (or waiver) as of the date of enactment of this section or enrolls for benefits under such plan (or waiver) during the period beginning on such date of enactment and ending the last day of the month in which the emergency period described in subsection (a) ends shall be treated as eligible for such benefits through the end of the month in which such emergency periods ends unless the individual requests a voluntary termination of eligibility or the individual ceases to be a resident of the State; or
4. The State does not provide coverage under such plan (or waiver), without the imposition of cost sharing, during such quarter for any testing services and treatments for COVID– 19, including vaccines, specialized equipment, and therapies.

FAMILIES FIRST CORONAVIRUS RESPONSE ACT ("FFCRA"), Pub. L. No. 116-127 134 Stat. 208 (2020)

The Federal Register provides for additional policy and regulatory revisions in response to the COVID-19 public health emergency as follows:

This IFC [Interim Final Rule with Comment Period] adds a new subpart G, Temporary FMAP Increase During the Public Health Emergency for COVID–19, to 42 CFR part 433, including a new § 433.400. Section 433.400(a) describes the statutory basis for this provision, while § 433.400(b) provides definitions specific to this subpart. As described in detail below, § 433.400(c) requires states, as a condition for receiving the temporary FMAP increase, to maintain beneficiary enrollment in an eligibility group that provides one of three tiers of coverage through the end of the month in which the PHE for COVID–19 ends, except under the circumstances specified in paragraph (d). This provision generally does not require states to provide the exact same (or greater) amount, duration, and scope of medical assistance, or maintain the costsharing or PETI liability for a particular beneficiary at the same (or lower) level that was applicable to the beneficiary as of March 18, 2020 or subsequent date of initial enrollment during the PHE. Section 433.400 is effective immediately upon display of this rule.

Federal Register/Vol. 85, No. 216/Friday, November 6, 2020/Rules and Regulations 71163

"Statutory basis. This subpart interprets and implements section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA) and section 1902(a)94) and (a)(19) of the Social Security Act." 42 C.F.R.§ 433.400(a)

Federal regulation provides as follows: In order to claim the temporary FMAP increase for:

i. The quarter in which November 2, 2020, falls, a state must meet the requirements described in paragraph (c)(2) of this section from November 2, 2020, through the end of the quarter.
ii. Any quarter beginning after November 2, 2020, through the quarter in which the public health emergency for COVID-19, including any extensions, ends, a state must meet the requirements described in paragraphs (c)(2) of this section.

42 C.F.R. § 433.400(c)(1)

Federal regulation provides as follows:

Except as provided in paragraph (d) of this section, for all beneficiaries validly enrolled for benefits under the state plan, a waiver of such plan, or a demonstration project under section 1115(a) of the Act as of or after March 18, 2020, the state must maintain the beneficiary's enrollment as follows, through the end of the month in which the public health emergency for COVID-19 ends:

A. For beneficiaries whose Medicaid coverage meets the definition of MEC in paragraph (b) of this section as of or after March 18, 2020, the state must continue to provide Medicaid coverage that meets the definition of MEC, except as provided in paragraph (c)(2)(i)(B) of this section.
B. For beneficiaries described in paragraph (c)(2)(i)(A) whom the state subsequently determines are eligible for coverage under a Medicare Savings Program eligibility group, the state satisfies the requirement described in paragraph (c)(2) of this section if it furnishes the medical assistance available through the Medicare Savings Program.

42 C.F.R. § 433.400(c)(2)(i)

Federal regulations provides the following definitions for purposes of this subpart –

Validly enrolled means that the beneficiary was enrolled in Medicaid based on a determination of eligibility. A beneficiary is not validly enrolled if the agency determines the eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility (if such last redetermination or renewal was completed prior to March 18, 2020) because of agency error or fraud (as evidenced by a fraud conviction) or abuse (as determined following the completion of an investigation pursuant to §§ 455.15 and 455.16 of this chapter) attributed to the beneficiary or the beneficiary's representative, which was material to the determination of eligibility. Individuals receiving medical assistance during a presumptive eligibility period in accordance with part 435, subpart L, of this chapter have

not received a determination of eligibility by the state under the state plan and are not considered validly enrolled beneficiaries for purposes of this section

Minimum essential coverage (MEC) has the meaning provided under section 5000A(f)1 of the Internal Revenue Code and implementing regulations at 26 CFR 1.5000A-2 and includes minimum essential coverage determined by the Secretary under 26 CFR 1.5000A-2(f). Refer ton Conclusion of Law #5.

Medicare Savings Program means the coverage of Medicare premiums and cost sharing furnished to individual described in, and determined by the state to be eligible under, section 1902(a)(10)(E)(i), 1902(a)(10)(E)(iii), or 1902(a)(10)(E)(iv) of the Act.

42 CFR 433.400(b)

AHCT correctly determined the Appellant was validly enrolled in Medicaid under the Husky D program as of ████ 2020.

AHCT correctly determined the Appellant enrolled in Medicare Part A and Part B as of ████ 2020 which qualifies as minimum essential coverage under the Affordable Care Act. However, AHCT correctly temporarily extended the Appellant's enrollment in the Husky D program throughout the public health emergency according to the FFCRA.

AHCT correctly determined the Appellant enrolled in the MSP whereas enrollment under the MSP satisfies the requirement under FFCRA and 42 C.F.R. § 433.400(c)(2) which states that the state must maintain a beneficiary's enrollment under Medicaid through the end of the month in which the public health emergency for COVID-19 ends.

AHCT correctly discontinued the Appellant's Medicaid benefits under the Husky D program effective ████ ██ 2022 because the Appellant is enrolled in the MSP.

DECISION

The Appellant's appeal is denied.

Lisa A.Nyren
Lisa A. Nyren
Fair Hearing Officer

CC: Becky, AHCT
Mike Towers, AHCT
Debra Henry, 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, 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 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.