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

[redacted] **2022**
Signature Confirmation

[redacted]
[redacted]
Hearing # 191725

NOTICE OF DECISION

PARTY

[redacted]
[redacted]
[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2022, the Health Insurance Exchange Access Health CT ("AHCT") issued a Notice of Action ("NOA") to [redacted] (the "Appellant"), discontinuing his HUSKY D Medicaid ("HUSKY D') healthcare coverage.

On [redacted] 2022, the Appellant requested an administrative hearing to contest the discontinuance of the HUSKY D.

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

On [redacted] 2022, in accordance with sections 17b-60, 17b-264 and 4-176e to 4-189, inclusive, of the Connecticut General Statutes ("Conn. Gen. Stat."), Title 45 Code of Federal Regulations ("C.F.R.") §§ 155.505(b) and 155.510 and/or 42 C.F.R. § 457.1130, OLCRAH held an administrative hearing by telephone. The following individuals participated in the hearing:

[redacted], Appellant
[redacted] Appellant's legal counsel
Cathy Davis, AHCT Representative
Carla Hardy, Hearing Officer

The hearing record remained open until [redacted] 2022, for AHCT and the Appellant to submit additional evidence.

On [redacted] 2022, the Hearing Officer extended the closing the hearing record at the request of the Appellant's representative. Additional evidence was received. The hearing record closed on [redacted], 2022.

STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT correctly discontinued the HUSKY D healthcare coverage effective [redacted] 2022.

FINDINGS OF FACT

1. The Appellant is the only person in his household. (Testimony)

2. The Appellant is [redacted] years old. (Hearing Record)

3. The Appellant has been active of HUSKY D since [redacted] 2019. (Appellant's Testimony)

4. The Appellant receives $1,443.00 monthly in Social Security Disability. He is a recipient of Medicare. (Appellant's Testimony)

5. The Appellant was granted the Medicare Savings Program ("MSP") as a Qualified Medicare Beneficiary in [redacted] 2019. (Hearing Summary)

6. On [redacted] 2020, Alex M. Azar II, the former Secretary of Health and Human Services declared that a Public Health Emergency ("PHE") exists because of the Coronavirus Disease 2019 (COVID-19) pandemic. (Appellant's Exhibit A: Public Health Emergency Declarations from the Office of the Assistant Secretary for Preparedness & Response)

7. The PHE was renewed several times between on [redacted] 2020, and [redacted] 2022, and most recently on [redacted] 2022. (Exhibit A)

8. The Appellant remained eligible for HUSKY D because of the continuous coverage rule in Section 6008 of the Families First Coronavirus Response Act ("FFCRA") through [redacted] 2022. (Hearing Summary)

9. On [redacted] 2022, AHCT issued a notice to the Appellant discontinuing the HUSKY D coverage because he is eligible for Medicare. (Exhibit 1: NOA, [redacted]/22; Hearing Summary)

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] 2022. Therefore, this decision is due not later than [redacted] 2022. However, the hearing, which was originally scheduled to close on [redacted], 2022, remained open until [redacted] 2022, which caused a 21-day delay. Therefore, this decision is due not later than [redacted] 2022.

CONCLUSIONS OF LAW

1. Section 17b-260 of the 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. Section 17b-264 of the Conn. Gen. Stat. 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 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 C.F.R. § 435.119 provides for coverage 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
   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 enrolled in benefits under Medicare part A or part B.

7. Title 42 C.F.R. § 433.10(b) provides in relevant part for the *Federal medical assistance percentage (FMAP)—Computations.* The FMAP is determined by the formula described in section 1905(b) of the Act…

8. Title 42 C.F.R. § 433.400 provides for continued enrollment for temporary FMAP increase. (a) *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).

9. Title 26 C.F.R. § 1.5000A-2(a) provides that 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 other 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.

10. Federal Register Vol. 85. No 216 (F)(4) provides in relevant part that Interim Final Rule with Comment Period ("IFC") added subpart G, Temporary FMAP Increase During the Public Health Emergency for COVID-19, to 42 CFR part 433, including a new § 433.400.

11. Title 42 C.F.R. § 433.400(b) provides that the definition of Medicare Savings Program means the coverage of Medicare premiums and cost sharing furnished to individuals 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.

    AHCT correctly determined that the Appellant's eligibility for the Medicare Savings Program meets the definition for minimum essential coverage.

12. Title 42 C.F.R. § 433.400(c)(2) provides 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.

13. Title 42 C.F.R. § 433.400(c)(2)(i)(A) provides 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.

14. Title 42 C.F.R. § 433.400(c)(2)(i)(B) provides 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.

    Because the Appellant receives coverage under a Medicare Savings Program which meets the definition of minimum essential coverage as defined by regulation, AHCT correctly determined that they are not required to extend Medicaid coverage for the Appellant through the end of the month in which the public health emergency for COVID-19 ends.

On [redacted], 2022, AHCT correctly discontinued the Appellant's HUSKY D Medicaid coverage effective [redacted] 2022.

DISCUSSION

On [redacted] 2020, the Centers for Medicaid and Medicare Services issued a new regulation reinterpreting the continuous coverage rule in Section 6008 of the Family First Coronavirus Response Act. The continuous coverage rule does not apply if the beneficiary maintains minimum essential coverage as defined by the regulation. The Appellant's eligibility for Medicare for A and B with a Medicare Savings Plan meets the definition of minimum essential coverage.

The Appellant's attorney asserted that the Department erred when it terminated the Appellant's HUSKY D based on its implementation of the Interim Final Rule, arguing that the Rule is invalid. The Appellant's argument is without merit; the Department must act in accordance with federal regulations governing the Medicaid program. Therefore, AHCT was correct to discontinue the HUSKY D Medicaid coverage effective [redacted] 2022.

DECISION

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

Carla Hardy
Carla Hardy
Hearing Officer

Pc: Cathy Davis, Becky Brown, Mike Towers, AHCT
Marjori Kapsis, Shannon Laplante, Department of Social Services
[redacted]

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.