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

2022
Signature Confirmation

Case ID #
Client ID #
Request # 192297

NOTICE OF DECISION
PARTY

On 2022, the Health Insurance Exchange, Access Health CT ("AHCT") issued a notice of action to (the "Appellant") discontinuing the Appellant's Medicaid/Husky D assistance 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, in accordance with sections 17b-60, 17b-264, and 4-176e to 4-184, inclusive, of the Connecticut General Statutes, (Medicaid/HUSKY A, D), Title 45 Code of Federal Regulations ("C.F.R.") §§ 155.510 (APTC/CSR) and/or 42 C.F.R. § 457.1130 (HUSKY B), OLCRAH held an administrative hearing by telephone.

The following individuals participated in the hearing:

Appellant
Cathy Davis, AHCT Representative
Christopher Turner, Hearing Officer

STATEMENT OF THE ISSUE

The issue is whether AHCT's action to discontinue the Appellant's Husky D assistance was correct.

FINDINGS OF FACT

1. On [redacted] 2022, AHCT sent the Appellant a notice indicating her eligibility for Husky D will end on [redacted] 2022, due to her receipt of the Department's Medicare Savings Program ("MSP") effective [redacted] 2021. (Exhibit 1: Notice)

2. On [redacted] 2022, an administrative hearing was held. The Appellant agreed with AHCT's decision to close her Husky D assistance but requested the Department/AHCT pay for her medical procedure performed in [redacted]. (Hearing record; Testimony).

3. On [redacted] 2022, an e-mail was received from the Appellant indicating her medical coverage issue was resolved. Because of this, there has been no "action" taken to deny the Appellant's request for medical services covered under the HUSKY D program. (Appellant's Exhibit A: E-mail)

4. The Appellant is [redacted] years old (DOB [redacted]) and is considered a household of one. (Record; Appellant's testimony)

5. The Appellant has been a recipient of Medicare Part A and B since [redacted] 2021. Medicare Part A and Part B are considered Minimum Essential Coverage. (Record, Appellant's testimony)

6. The issuance of this decision is timely under Connecticut General Statutes ("Conn. Gen. Stat") § 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, with the decision due no later than [redacted] 2022. (Hearing Record)

CONCLUSIONS OF LAW

1. Conn. Gen. Stat. § 17b-2 provides that the Department of Social Services is designated as the state agency for the administration of (6) the Medicaid program pursuant to Title XIX of the Social Security Act.

   Conn. Gen. Stat. § 17b-260 provides 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.

Conn. Gen. Stat. § 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.

The Department has the authority to administer the Medicaid program following the provisions established by the Social Security Amendments of 1965.

2. 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.

   45 C.F.R. § 155.505(c) provides that Exchange eligibility appeals may be conducted by - (1) 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.

   45 C.F.R. § 155.505(d) provides that an appeals process established under this subpart must comply with § 155.110(a).

   AHCT is the Department's designated state exchange to administer the Health Insurance Exchange program.

   AHCT acted within its authority to consider the Appellant's ongoing Husky D eligibility and determine whether she meets the program requirements.

3. 42 C.F.R. § 431.211 provides for advance notice. The State or local agency must send a notice at least 10 days before the date of action, except as permitted under §§431.213 and 431.214.

   42 C.F.R. § 431.245 provides for notifying the applicant or beneficiary of a State agency decision. The agency must notify the applicant or beneficiary in writing of – (a) The decision; and (b) The right to request a State agency hearing or seek judicial review, to the extent that either is available to him/her.

AHCT properly notified the Appellant in writing on [redacted] 2022, of the proposed HUSKY D discontinuance effective [redacted] 2022, and her rights to a Hearing/Appeal.

4. 42 C.F.R. § 435.119 (b) provides that 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. § 433.400 provides for continued enrollment for temporary FMAP increase and defines: (b) 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.

    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).

    Public Health emergency has the same definition provided in § 400.200 of this chapter.

    26 C.F.R. § 1.5000A-2 defines minimum essential coverage and provides (a) *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.

    (b) Government-sponsored program (1) *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).

    AHCT correctly discontinued the Appellant's HUSKY D coverage due to a change in federal law.

AHCT correctly determined the Appellant is enrolled in Medicare Part A and B.

Medicare Part A meets the definition of minimum essential coverage.

5. "The Department's Uniform Policy Manual ("UPM") is the equivalent of state regulation and, as such, carries the force of law." Bucchere v. Rowe, 43 Conn. Supp. 175, 178 (1994) (citing Conn. Gen. Stat. § 17b-10; Richard v. Commissioner of Income Maintenance, 214 Conn. 601, 573 A.2d 712 (1990)).

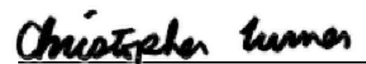
   UPM § 1570.25 (c)(2)(k) provides that the Fair Hearing Official renders a Fair Hearing decision in the name of the Department, in accordance with the Department's policies and regulations, to resolve the dispute.

   "When the actions of the parties themselves cause a settling of their differences, a case becomes moot." McDonnell v. Maher, 3 Conn. App. 336 (Conn. App. 1985), citing, Heitmuller v. Stokes, 256 U.S. 359, 362-3, 41 S.Ct. 522, 523-24, 65 L.Ed. 990 (1921).

   The Appellant has withdrawn her appeal since her provider has received payment authorization for her [redacted] 2022 medical service procedure. Accordingly, the Appellant's appeal issue has been resolved, therefore there is no issue on which to rule.

DECISION

The Appellant's appeal is dismissed as moot.



Christopher Turner
Hearing Officer

Cc: Becky Brown, AHCT
Mike Towers, AHCT
Cathy Davis, AHCT

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

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, 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 the 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 the 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 to 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 her designee following §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.