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

[redacted] **2022**
SIGNATURE CONFIRMATION

CASE # [redacted]
CLIENT# [redacted]
REQUEST# [redacted]

NOTICE OF DECISION
PARTY

[redacted]

PROCEDURAL BACKROUND

On [redacted], the Health Insurance Exchange, Access Health CT ("AHCT") sent [redacted] (the "Appellant"), a Notice of Action ("NOA") granting Husky D Medicaid coverage, effective [redacted] 2022 through [redacted] 2023.

On [redacted] 2022, the Appellant requested an administrative hearing to contest a discontinuance of his Husky D Medicaid coverage.

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, OLCRAH issued a notice rescheduling the administrative hearing for [redacted] 2022.

On [redacted] 2022, in accordance with sections 17b-60, 17b-61 and 4-176e to 4-189 inclusive, of the Connecticut General Statutes, OLCRAH held a telephonic administrative hearing. The following individuals participated in the hearing:

Appellant's Authorized Representative ("AREP"), [redacted]
AHCT Representative, Cathy Davis
Hearing Officer, Joshua Couillard

The hearing record was held open for one additional day, until [redacted] 2022, to allow AHCT to provide more information.

STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT correctly discontinued the Appellant's Husky D Medicaid coverage.

FINDINGS OF FACT

1. The Appellant is [redacted]-years-old [DOB: [redacted], 1965]. (AREP's Testimony)

2. The Appellant was a recipient of Husky D Medicaid coverage. (AHCT Representative's Testimony, Hearing Record)

3. The Appellant has received Social Security benefits since [redacted]. (AREP's Testimony)

4. On [redacted] 2022, AHCT issued the Appellant a NOA which stated that his health care renewal had been processed. The notice also granted the Appellant Husky D Medicaid coverage, effective [redacted] 2022 through [redacted] 2023. (Exhibit 2: 1301 Notice of Action)

5. On [redacted] 2022, the Appellant's Husky D Medicaid coverage was discontinued. (Exhibit 3: Eligibility Results, AHCT Representative's Testimony)

6. AHCT failed to issue a NOA to the Appellant or his AREP regarding the Husky D Medicaid discontinuance. (Exhibit 5: AHCT E-Mail Correspondence)

7. On [redacted], 2022, the Appellant qualified for, and began receiving, Medicare Parts A and B coverage. (AREP's Testimony, AHCT Representative's Testimony)

8. There was no evidence submitted showing that the Appellant was enrolled in any other form of Medicaid coverage after [redacted] 2022. (Hearing Record)

9. 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 hearing request was received on [redacted] 2022. The hearing was delayed [redacted] days due to rescheduling, and the record was left open for [redacted] after the hearing in order to allow for AHCT to submit more information; therefore, this decision is due no later than [redacted] 2022.

CONCLUSIONS OF LAW

1. "*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." Connecticut General Statutes ("Conn. Gen. Stat.") § 17b-260

2. "*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." Conn. Gen. Stat. § 17b-264

3. "*Options for Exchange Appeals*. 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." Title 45 of the Code of Federal Regulations ("C.F.R.") § 155.505(c)(1)

4. "*Eligible Entities*. An appeals process established under this subpart must comply with § 155.110(a)." 45 C.F.R. § 155.505(d)

5. "*Eligible Contracting Entities*. 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. § 155.110(a)

   AHCT is the State of Connecticut's Health Insurance Exchange ("HIX") where consumers can enroll in affordable healthcare plans, including Husky D Medicaid.

6. "*Eligibility*. 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)

7. "*Federal Medical Assistance Percentage ("FMAP")*. Computations. The FMAP is determined by the formula described in section 1905(b) of the Act… The formula provides for squaring both the State and national average per capita incomes; this procedure magnifies any difference between the State's income and the national average. Consequently, Federal matching to lower income States is increased, and Federal matching to higher income States is decreased, within the statutory 50-83 percent limits…" 42 C.F.R. § 433.10(b)

8. "*General Requirements*. 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." 42 C.F.R. § 433.400 (c)(2)

AHCT correctly administered Husky D Medicaid coverage to the Appellant.

9. "*Definitions*. 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)." 42 C.F.R. § 433.400(b)

10. "*Minimum Essential Coverage*. 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." 26 C.F.R. § 1.5000A-2(a)

11. "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)(ii)

12. "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." 42 C.F.R. § 433.400(c)(2)

13. "*Definitions*. 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." 42 C.F.R. § 433.400(b)

14. "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." 42 C.F.R. § 433.400(c)(2)(i)(A)

15. "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)(B)

16. "If a state determines that a validly enrolled beneficiary is no longer eligible for Medicaid, including on a procedural basis, the state meets the requirements described in paragraph (c)(2)(i), (ii), or (iii) of this section by continuing to provide the same Medicaid coverage that the beneficiary would have received absent the determination of ineligibility." 42 C.F.R. § 433.400(c)(2)(iv)

There was no evidence or testimony submitted during the hearing to show that the Appellant was validly enrolled in the Medicare Savings Program or any other form of Medicaid coverage after [redacted] 2022. The Appellant's coverage did not meet the Minimum Essential Coverage requirement.

AHCT incorrectly discontinued the Appellant's Husky D Medicaid coverage prior to the end of the Public Health Emergency.

17. "*Content of Notice.* A notice required under § 431.206 (c)(2), (c)(3), or (c)(4) of this subpart must contain - (a) A statement of what action the agency, skilled nursing facility, or nursing facility intends to take and the effective date of such action; (b) A clear statement of the specific reasons supporting the intended action; (c) The specific regulations that support, or the change in Federal or State law that requires, the action; (d) An explanation of - (1) The individual's right to request a local evidentiary hearing if one is available, or a State agency hearing; or (2) In cases of an action based on a change in law, the circumstances under which a

hearing will be granted; and (e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested." 42 C.F.R. § 431.210

18. "*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. § 431.211

AHCT was incorrect when it failed to issue a NOA to the Appellant or his AREP regarding the Husky D Medicaid discontinuance.

DISCUSSION

The discontinuance of the Appellant's Husky D Medicaid coverage was incorrect. There was no evidence or testimony submitted during the hearing from either party that the Appellant was active on any Medicaid or Medicare Savings Plan coverage after the [redacted] 2022 Husky D discontinuance. Therefore, the Appellant's health insurance does not meet the Minimum Essential Coverage requirement. As defined in 42 C.F.R. § 433.400(c)(2)(iv) and 42 C.F.R. § 433.400(c)(2), AHCT must maintain the Appellant's Husky D Medicaid coverage through the end of the month in which the Public Health Emergency for COVID-19 ends if the Minimum Essential Coverage requirement is not met.

Furthermore, AHCT failed to provide the Appellant or his AREP with a Notice of Action regarding the discontinuance. The only notice that was submitted for this hearing was the [redacted] 2022 Notice of Action which granted the Appellant Husky D coverage through [redacted].

AHCT's decision to discontinue the Appellant's Husky D Medicaid coverage is overturned.

DECISION

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

ORDER

1. Reinstate the Appellant's Husky D Medicaid coverage, effective [redacted] 2022.

2. Compliance with this order is due back to the undersigned hearing officer no later than [redacted] 2022.

Joshua Couillard

Joshua Couillard
Fair Hearing Officer

CC: Becky Brown, AHCT; Mike Towers, AHCT; Cathy Davis, 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 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.