access health CT

Connecticut Department of Social Services

Making a Difference

Hearing/Appeals Support

Process & Procedure Guide

Document Controls

Document Purpose

The purpose of this document is to provide guidance to the third-party (contractor) Appeals Support Unit in executing the appeals support processes that are within their remit. The document includes an overview of the broader appeal process in order to provide context for the third-party support tasks.

Document Scope

The appeals process allows a consumer/client/appellate to dispute adverse eligibility determinations. The program scope for this document is limited to QHP/APTC/CSR, MAGI-based Medicaid and CHIP healthcare determinations made by the HIX/Tier-1 system.

Even within this program scope, some types of appeals are considered outside of the jurisdiction of DSS and are routed to Access Health CT for resolution, i.e., DSS may be the common door for appeal submission, but it does not handle the appeals process for every type of appeal.

Intended Audience

The primary audiences for this document are the third-party Appeals Support Unit staff and the Appeals Support Unit trainers.

Other interested parties include:

- DSS Management
- DSS Office of Legal Counsel, Regulations and Administrative Hearings (OLCRAH)
- DSS Cadres
- Access Health CT legal and policy staff.

Versioning Approach

Draft versions of this guide will be noted as V0.1. When a version is initially approved, it will be promoted to V1. Whether to then use a decimal (“dot release”) or a full integer release is discretionary based on the degree of change.

Note: New and updated Hearing Summary Document templates or models (worked examples) will be added to Appendix D. Such changes would be considered a minor and targeted release and could be approved by OLCRAH alone.

Version Control

Version	Date	Author(s)	Change
1.0	1/27/2016	Rahul Rai	Initial Version
2.0	06/27/2017	Joe Huertas	A significant overhaul. Includes a more complete review and refinement of text throughout the document.

Key Reviewers

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Appeals Process - Overview

High Level Description

When a consumer applies for health care coverage using Access Health CT (AHCT), the shared HIX/Tier-1 system provides an eligibility determination.

A consumer may not agree with an aspect of a HIX/Tier-1 eligibility decision. Constitutional due process principles and federal regulations give consumers the right to request a review of their eligibility determination. As such, DSS and AHCT have established a multi-path appeals process. The process is designed to ensure that consumers have both a practical and timely mechanism by which to file their appeal, and for that appeal to be handled in a timely manner.

> Note: *The right to appeal for APTC/CSR clients is regulatory in nature. For HUSKY clients, the right to appeal has its origin in both due process principles and federal regulations.*

The DSS Office of Legal Counsel, Regulations and Administrative Hearings (OLCRAH) has primary responsibility for processing consumer health care eligibility determination appeals. In carrying out its duties in this regard, the DSS uses a contracted third party to perform the research phase and the preparation of hearing support materials. The third party contractor is referred to as the Appeals Support Unit when operating in this support role.

The high-level flow of the appeals process is shown below:

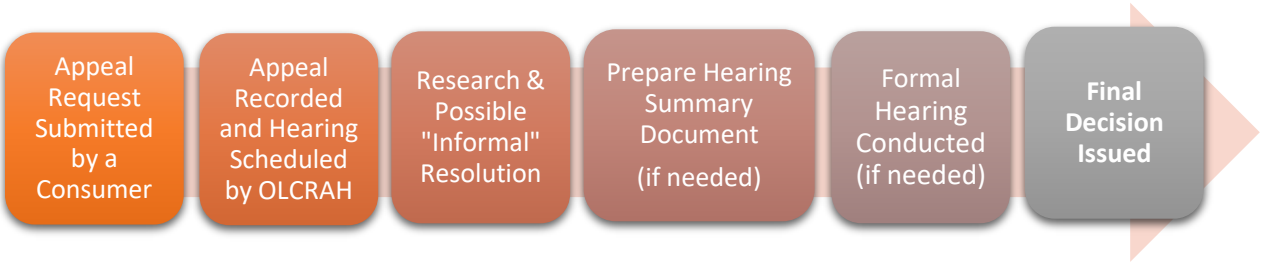


Figure 1. Highest Level View of the Appeals Process

The third-party support Appeals Support Unit is responsible for two steps in the above representative flow:

- **Research and Informal Resolution**

  The third party Appeals Support Unit gathers information on an appeal and the details behind the decision under review. This involves a conversation with the consumer (appellant) and can result in a withdrawal of the appeal if the situation is explainable to the consumer's satisfaction or if there is an action that can be taken that resolves the consumer's root issue.

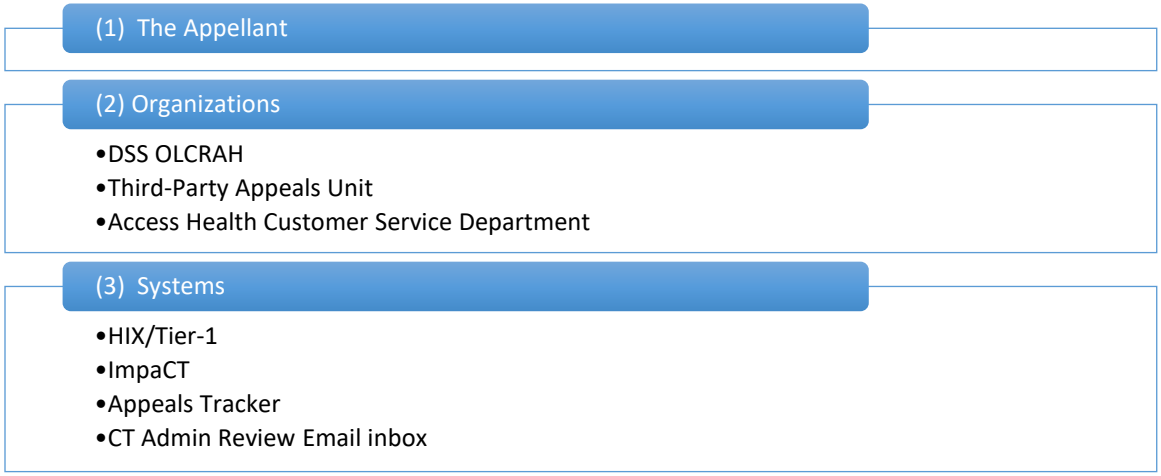
- **Prepare Hearing Summary Document**

  A *Hearing Summary Document* is a synopsis of the situation at issue and represents the State's case. This document is prepared by the third-party Appeals Support Unit for use by the Hearing Officer. Although prepared primarily for the Hearing Officer, to orient them to the hearing facts and issue, this document is also shared with the consumer (appellant) and their legal representative if they have one.

If an appeal remains unresolved upon reaching the scheduled hearing date, DSS Hearing Officers conduct an appeal hearing. The appeal hearing can be in-person or telephonic and all parties are represented and afforded the opportunity to state their case. The DSS Hearing Officer reviews a case and makes a finding. The decision of the Hearings Office is documented and distributed to all parties involved.

Process Components

The appeals process consists of the following stakeholders and computer systems:



The Appellant

The appellant is the formal name for the consumer who has been adversely impacted by an eligibility-related decision and has submitted an appeal. The scope for this processing guide is a subset of the determinations made by the HIX/Tier-1 system.

Organizations

DSS Office of Legal Counsel, Regulations and Administrative Hearings (OLCRAH)

The DSS Office of Legal Counsel, Regulations and Administrative Hearings (OLCRAH) is responsible for the Department's appeals process. Within OLCRAH, Processing Technicians and Hearings Officers directly support the appeals processes. In addition, DSS Public Assistance Consultants (PACs) may act in a liaison role to OLCRAH staff.

Third-Party Appeals Support Unit

Within a third-party contractor organization there are staff members who carry out the roles of Appeals Supervisor and Appeals Coordinators. Collectively, these individuals are referred to as the "Appeals Support Unit." In their capacity as an Appeals Supervisor or Appeals Coordinators, the contract staff represent DSS and AHCT. Specifically, they are not responsible for advocating for consumers/appellants, nor do they operate as a customer service organization.

Note: *The Appeals Support Unit is ultimately responsible for the timely and effective administration of their appeals-related work. As such, they may adjust staffing assignments as they feel appropriate*.

Access Health Customer Service Department

The Access Health Customer Service Department (formally the Issue Resolution Department or IRD) is the point of contact for referral of specialized AHCT appeals or system issues. The Access Health Customer Service Department performs a desk-check (this is also known as a "desk review") of referred appeals, performs corrective system actions when appropriate, and can in turn refer appeals to the AHCT legal department.

Systems

HIX/Tier-1

This is a shared system jointly owned by DSS and AHCT. The *HIX/Tier-1* system performs the eligibility and enrollment determinations for QHP, Advanced Premium Tax Credits (APTCs), Cost Share Reductions (CSRs) and MAGI-based Medicaid and CHIP.

DSS is Connecticut's official agency for the administration of both the Medicaid and CHIP programs. Since DSS shares ownership of the HIX/Tier-1 system, the Medicaid and CHIP determinations are deemed to be DSS determinations. The HIX/Tier-1 Medicaid and CHIP determinations and enrollments/discontinuances are sent to the ImpaCT system.

The eligibility and enrollment determinations that are made by the shared HIX/Tier-1 system are the source of the appealable decisions that are the focus of this processing guide.

ImpaCT

ImpaCT is the main DSS eligibility system. ImpaCT provides eligibility and case management for non-MAGI Medicaid as well as for non-Medical programs such as SNAP (nutrition assistance) and TFA (Temporary Family Assistance - economic assistance).

The HIX/Tier-1 Medicaid and CHIP enrollments and discontinuances are routed to ImpaCT and stored in ImpaCT in order to leverage common ImpaCT functions (e.g., medical card provisioning, an interface to the claims processing system, etc.) and to provide a consolidated cross-program view of a DSS consumer/client.

The Medicaid and CHIP appeals, as well as the APTC and CSR appeals, are also logged into ImpaCT. ImpaCT is considered the system of record for these appeals.

Appeals Tracker

The third-party contractor is responsible for maintaining an *Appeals Tracker.* The tracker a structured database used to create and update appellant appeals-related information and to support appeals-related tasks. The Appeals Support Unit uses the *Appeals Tracker* throughout the process of handling an appellant's appeal.

CT Administrative Review Email inbox

The *CT Administrative Review Email inbox* is maintained by the third-party Appeals Support Unit. This inbox receives all communications from OLCRAH regarding new and existing appeals.

Types of Appeals – Introduction

Not everything can be appealed. A consumer can appeal a HIX/Tier-1 adverse decision about their health coverage, such as:

- Ineligibility for HUSKY, e.g., if they think we made a mistake regarding their current income, citizenship, immigration status, or residency.
- Ineligibility due to failure to verify conditions of eligibility that affect APTC/CSR or HUSKY determinations.
- The amount of their APTCs, e.g., if they think we made a mistake on their household size or income.

There are some types of AHCT appeals, while valid for the consumer to submit, are specialized and outside of DSS's jurisdiction. These specialized AHCT appeals are beyond the scope of this processing guide and include:

- A dispute over eligibility for a QHP, e.g., if the consumer thinks we made a mistake on their citizenship, immigration status, or residency.
- A dispute over the denial of a special enrollment reason.

- A dispute over a denial of APTCs due to a failure to reconcile (FTR) last year's tax credits.
- Consumer's disputing discontinuance of APTCs/QHPs for failure to pay premium.

Specialized AHCT appeals are typically routed to the Access Health Customer Service Department for review and handling. If the Appeals Support Unit identifies such an appeal, prior to forwarding the appeal to AHCT, they would typically confirm their understanding with OLCRAH.

General Perspective of the Third-Party Contractor Role

The focus of the third-party Appeals Support Unit is in preparing the Hearing Summary document that DSS Hearing Officers need in order to adjudicate appeals that have proceeded to the formal hearing stage. This is an important framing concept because it shapes the general approach to the support provided by and the work done within the Appeals Support Unit, and as such:

- As the Appeals Support Unit develops the Hearing Summary document, its primary activity is identifying and clearly laying out the facts of each appeal, and clearly stating the basis upon which an eligibility decision was rendered.
- In laying out the factual basis in each appeal, the Appeals Support Unit is not acting in the role of an advocate for the appellant, but rather in a supporting role for DSS and AHCT.
- In providing support to DSS, the Appeals Support Unit is responsible for preparing effective Hearing Summary documents, but not for processing an application for the appellant, i.e., the Appeals Support Unit is not a customer service center
- An effective Hearing Summary document is one that provides the facts and the basis of the eligibility determination as opposed to one that simply lists the chronology of events.

Within this framework, the Appeals Support Unit should always be mindful of the need to treat appellants with respect and at all times recognize the rights of the appellant.

Guidance for Different Appeal Types and Scenarios

Appeals typically arise when a system action results in eligibility being denied for an initial or change-reporting application or eligibility being discontinued due to an appellant inaction. Consumer inactions that can cause a discontinuation of coverage include the failure of a consumer to renew their eligibility in a timely fashion or failure to provide adequate verification of attested facts within the reasonable opportunity period (ROP).

The following is a list of the most common and distinct types of appeals and their typical process for resolution. A number of these appeal types can sometimes be resolved to the appellant's satisfaction without the need to progress through to the formal hearing.

- **Eligibility Rules Clarification**

  This is not a specific type of appeal, but is a general outcome that can happen for any appeal type.

  The dialogue between the Appeals Coordinator and the appellant can clarify for the appellant the basis of an eligibility determination. Explaining the eligibility rules that yielded the adverse eligibility determination may be sufficient in satisfying the appellant's concern, at which point they may request a withdrawal of the appeal. Refer to the "An Appellant Withdraws an Appeal" section for more guidance on this process.

  Clarifying the basis of an eligibility determination could occur during the initial informal research step with the appellant or could occur in subsequent conversations.

  While the appellant may always withdraw their appeal, it is important to remember at no time may the Appeals Coordinators (or anyone else) encourage or ask them to do so. This applies even if the appellant's position has no support in the law and the Appeals Coordinator or other staff do not see any reasonable basis or merit to the appellant's position.

- **Appellant Reported Data Incorrectly**

  In this instance the nature of the root cause means the eligibility determination was actually correct based on the information provided. In this circumstance, the appellant

should be provided the guidance they need to use existing channels to submit a new application if that is possible.

Identifying a self-attestation data-entry issue could occur during the initial informal research step with the appellant (previously described) or could occur in subsequent conversations later in the investigation.

In this instance, providing a solution to the appellant may be sufficient in satisfying the appellant's appeal. At the point the appellant's issue has been resolved to their satisfaction, the appeal may be withdrawn if the appellant approves. Refer to the "An Appellant Withdraws an Appeal" section for more guidance on this process.

- **Professional User Data Entry Error**

  If a professional user (ahCT call center, paper processing center, DSS Benefit Center or DSS local office) entered eligibility-affecting data incorrectly then it is possible that the adverse eligibility determination was incorrect. In this circumstance, it is acceptable for the Appeals Coordinator to fix the data entry error and resubmit the application for determination.

  As in previous instances, resolving this root cause issue may be sufficient in satisfying the appellant's appeal. At the point the appellant's issue has been resolved to their satisfaction, the appeal may be withdrawn if the appellant approves. Refer to the "An Appellant Withdraws an Appeal" section for more guidance on this process.

- **Known System Issue**

  When the adverse eligibility determination is the result of a known system issue, the Appeals Coordinator can perform the workaround and re-submit the application. If the workaround requires an override then the Appeals Coordinator should refer to the DSS cadre for HUSKY cases and refer to the Access Health Customer Service Department for QHP/APTC cases.

  As in previous instances, resolving the root cause issue may be sufficient in satisfying the appellant's appeal. At the point the appellant's issue has been resolved to their satisfaction, the appeal may be withdrawn if the appellant approves. Refer to the "An Appellant Withdraws an Appeal" section for more guidance on this.

- **HUSKY Failure to Renew**

  The HIX/Tier-1 system operates the HUSKY renewal process. The renewal process is initiated 60-days prior to the current coverage end date. At this time, consumers are sent a renewal notice; either a 1305, 1605, 1606, 1607 or 1608, depending on the details of their case. The consumers who receive 1605 renewal notices do not typically have to do anything and they will be auto-renewed. The other types of notice recipients are required to update their information in order to effectuate their renewal.

  Between 15 to 12 days before the last day of coverage, the consumers who were sent 1605 renewal notices have their auto-renewal finalized and the other types of notice recipients, who have been non-responsive to that point, will have their coverage ended; both sets of consumers receive a 1337 notice detailing the action.

  If the consumer failed to renew in a timely fashion, they will receive a 1337 discontinuance notice. This is a valid and correct determination. However, the consumer can (possibly) rectify their situation by submitting a new application through one of the various channels, e.g., the AHCT call center, using the online consumer web portal, via a paper application, or in-person at a DSS office. The consumer has up to 90 days past their closure date (the “reconsideration window”) to submit an application, and if they are otherwise eligible, they will be reinstated without any gaps in coverage.

  The failure to respond to a HUSKY renewal notice likely means that the adverse determination was correct. However, providing the appellant with the guidance to submit a new application, may be sufficient in satisfying the appellant’s issue. At the point the appellant’s issue has been resolved to their satisfaction, the appeal may be withdrawn if the appellant approves. Refer to the “An Appellant Withdraws an Appeal” section for more guidance on this process.

- **HUSKY 90-Day Disenrollment**

  The HIX/Tier-1 system affords a person with a 90-day window to verify key information (e.g., employment income) that it was unable to verify electronically during the application or change reporting process.

  If someone submits an appeal for this type of issue and the data was previously verified and is considered essentially static, then the Appeals Coordinator can treat this like a

known system issue (described previously). Data that falls into this "static" category (i.e., once verified, always verified) includes proof of citizenship, proof of identity, and proof of the 5-year bar. The Appeals Coordinator can reapply for the appellant and verify the data.

Alternatively, if the appellant simply failed to verify their data in time (90-days) then the Appeals Coordinator can advise the appellant to reapply in order to get another 90 days of grace period to verify their data. The Appeals Coordinator should not provide this advice if this is the appellant's second consecutive disenrollment for failure to verify.

Resolving this root cause issue may be sufficient in satisfying the appellant's appeal. At the point the appellant's issue has been resolved to their satisfaction, the appeal may be withdrawn if the appellant approves. Refer to the "An Appellant Withdraws an Appeal" section for more guidance on this.

- **QHP 90-Day Disenrollment**

  The HIX/Tier-1 system affords a person with a 90-day window to verify key information (e.g., annual income) that it was unable to verify electronically during the application or change reporting process.

  QHP denials are outside the scope of this support process. Typically OLCRAH will try to filter these out before they are sent to the Appeals Support Unit. If the Appeals Coordinator discovers that the appellant is disputing a QHP 90-day disenrollment decision then the Appeals Coordinator should forward the appellant appeal to the Access Health Customer Service Department who will take the matter forward from that point (prior to forwarding, the coordinator should confirm a common understanding with OLCRAH).

  The Appeals Coordinator should make a relevant entry into the Appeals Tracker to ensure the DSS activity with respect to that appeal is appropriately closed.

- **Denial of QHP**

  A consumer could be denied eligibility for a QHP because of a citizenship, immigration status, or residency based decision.

General QHP denials are outside the scope of this support process. Typically OLCRAH will try to filter these out before they are sent to the Appeals Support Unit. If the Appeals Coordinator discovers that the appellant is disputing a special enrollment decision then the Appeals Coordinator should forward the appellant appeal to the Access Health Customer Service Department who will take the matter forward from that point (prior to forwarding, the coordinator should confirm a common understanding with OLCRAH).

The Appeals Coordinator should make a relevant entry into the Appeals Tracker to ensure the DSS activity with respect to that appeal is appropriately closed.

- **Failure to Reconcile (FTR)**

  A consumer receives APTCs based on their projected taxable income. At the end of the year they must file taxes and the IRS will determine whether APTCs were overpaid or underpaid based on the person's actual taxable income, i.e., whether taxes will be refunded or additional payments are needed. For example, if a consumer does not file taxes with the IRS, then the IRS cannot adjudicate the APTC payments and it is termed as a failure to reconcile. A consumer cannot receive APTCs for a new plan year when they have failed to reconcile past APTCs.

  FTR denials are outside the scope of this support process. Typically OLCRAH will try to filter these out before they are sent to the Appeals Support Unit. If the Appeals Coordinator discovers that the consumer is disputing a FTR decision then the Appeals Coordinator should forward the consumer appeal to the Access Health Customer Service Department who will take the matter forward from that point (prior to forwarding, the coordinator should confirm a common understanding with OLCRAH).

  The Appeals Coordinator should make a relevant entry into the Appeals Tracker to ensure the DSS activity with respect to that appeal is appropriately closed.

- **Special Enrollment Denial**

  To enroll in a QHP outside of the annual Open Enrollment period requires a consumer to have a qualifying life event, e.g., marriage, relocation to the state, and loss of health coverage (other than for non-payment of premiums).

Special enrollment denials are outside the scope of this support process. Typically OLCRAH will try to filter these out before they are sent to the Appeals Support Unit. If the Appeals Coordinator discovers that the consumer is disputing a special enrollment decision then the Appeals Coordinator should forward the consumer appeal to the Access Health Customer Service Department who will take the matter forward from that point (prior to forwarding, the coordinator should confirm a common understanding with OLCRAH).

The Appeals Coordinator should make a relevant entry into the Appeals Tracker to ensure the DSS activity with respect to that appeal is appropriately closed.

- **Dispute over APTC Amount**

  This type of appeal will typically progress through to a hearing using the general process for appeals (unless the appellant understood and accepted an Appeals Coordinator's explanation).

  The distinction in this scenario is that the Appeals Coordinator will independently calculate/verify the APTC amount using a calculator provided by Access Health CT. They will make a note of the number of people in the tax household (used for establishing the poverty level), the number of people who qualify for the tax credits and the second lowest cost silver plan (SLCSP); these details will be added to the hearing summary.

- **90-Day Reduction in APTC**

  This type of appeal will typically progress through to a hearing using the general process for appeals (unless the appellant understood and accepted an Appeals Coordinator's explanation).

  The distinction in this scenario is that these types of appeals are in essence a failure to provide verification and that is the explanation that must be provided in the Hearing Summary Document. Specifically, the Appeals Coordinator does not have to provide an APTC calculation.

  Note: *If the new APTC amount is not zero it is quite possible that the annual income that was used in the determination is unknown (not*

displayed) as it will have come from the IRS and is considered protected data.

Denial of APTCs

These would typically progress through to a hearing using the general process for appeals.

The distinction in this scenario is that a non-financial denial of APTCs is treated differently than a dispute over the calculated amount of APTCs, i.e., a denial of APTCs is different from a calculation that renders zero. For example, APTCs can be denied because a married couple is not filing jointly or because the household members qualified for HUSKY or had other creditable coverage. Therefore, in this situation the Hearing Summary Document does not need to include an APTC calculation.

Note: *It is generally better to seek to resolve an appeal prior to entering the formal hearing process when possible.*

Appeals Process – Process Flow Details

Consumers are provided a process through which they can formally appeal an adverse eligibility determination for QHP/APTC, MAGI Medicaid and/or CHIP healthcare coverage made by the HIX/Tier-1 system. A simple Level 1 process diagram of that appeals process is shown below:

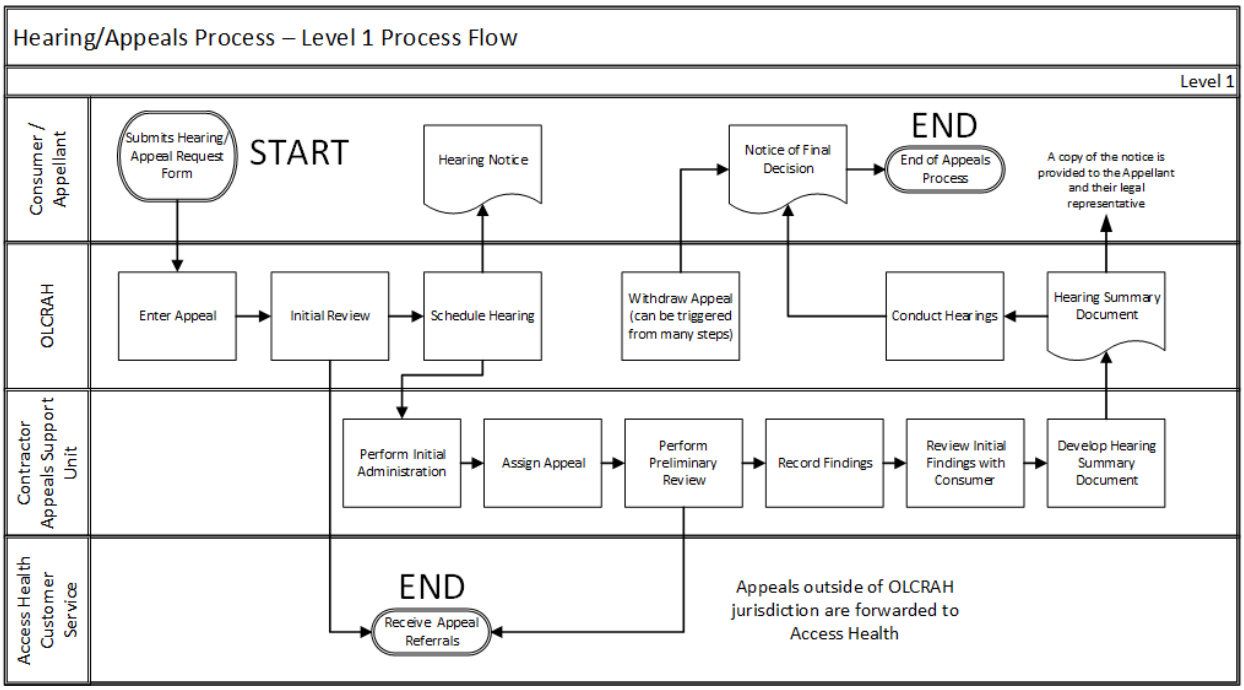


Figure 2. A High-level view of the basic appeal process

IMPORTANT NOTE

The key steps in the process flow diagram are described below. However, the scope of this document is strictly limited to the defining the processes that are assigned to the third-party support contractor.

The consumer submission and OLCRAH-based tasks are provided only for context and this document should not be considered as the definitive source of information on these process steps.

Consumer – Submits a Request for Appeal

Multi-Channel Submission

Consumers can initiate an appeal by submitting a Hearing/Appeal Request Form through any one of the following four channels:

- Call the DSS-ahCT Administrative Hearings unit at 855-306-8625 to get assistance in completing/submitting the form
- Fax the completed Appeal Request form to DSS at 860-424-4923
- Email the completed Appeal Request form to DSS at DSS-ahCT@ct.gov
- Mail via the USPS the completed Appeal Request form to:

  Department of Social Service
  Office of Legal Counsel, Regulations and Administrative Hearings
  55 Farmington Avenue
  Hartford, CT 06105

Incorrectly Mailed Appeals

On occasion consumers will submit their forms through alternate incorrect channels. For example, Hearing/Appeals Request Forms are sometimes mailed to the HIX/Tier-1 scanning center where they are scanned and are ultimately routed to the HIX/Tier-1 Unknown queue. It is even possible for an Appeals Form to be routed to the HIX/Tier-1 Verification queue when they are mailed with a verification cover sheet or uploaded by a consumer as if they were a verification document.

When forms end up in the wrong work queue, the individuals processing items in these queues escalate them to the Appeals Support Unit. The Appeals Support Unit then:

- stamps the date of receipt on the cover, and
- forwards the Hearing/Appeal Request Form to OLCRAH without further delay.

Speed is of the essence because OLCRAH is under a statutory mandate to ensure that Hearings are scheduled to occur on a date which is within thirty (30) days of the initial receipt even if mailed to the wrong address.

OLCRAH – Initial Processing

The following process steps are performed by OLCRAH and are out-of-scope for the third-party contractor, i.e., they are provided only for context.

Enter Appeal into the System

Upon receipt of an appeal request form, the first step the OLCRAH Processing Technician takes is to enter the appeal request into ImpaCT (the system of record). By entering this information into ImpaCT, DSS captures accurate data as part of the consumer's case record.

Perform Initial Review of Appeal

Once the data entry of the Appeal into ImpaCT is completed, the OLCRAH Processing Technician performs an initial review of the Hearing/Appeal Request Form and considers:

- **OLCRAH Jurisdiction**

  In the event the Appeal is related to a FTR denial, SEP denial, or QHP denial, the OLCRAH Processing Technician will forward the appeal to ahCT for further processing. The appeal is considered resolved with respect to DSS.

- **Appeal Submission Timeliness**

  The Processing Technician will review an appeal to determine that the submission date is within the timeliness window based on the date of the adverse action.

  If an appeal is not submitted within the timeliness window it will be denied, the consumer informed of the decision and ImpaCT will be updated with appropriate notes indicating the disposition of the appeal. The appeal is considered resolved with respect to DSS.

- **Issue Resolution**

  The Processing Technician will review the appeal request to determine if the issue appears to be resolved and therefore negates the need to forward the appeal to the Appeals Support Unit. In such a case, if the consumer considers their concern addressed and the consumer has agreed to withdraw their appeal, then the appeal is considered resolved with respect to DSS.

  OLCRAH will inform the consumer of the resolution and ImpaCT will be updated with appropriate notes indicating the disposition of the appeal.

  As part of closing the file on an appeal, the OLCRAH Processing Technician sends an Appeal Resolution Notice (ARN) to the consumer. The Appeals Technician will enter closing notes in both ImpaCT and the Appeals Tracking Database.

Schedule a Hearing

If an appeal is valid then the OLCRAH Processing Technician will schedule a hearing date for the appeal and mail a Hearing Notice, which includes the scheduled hearing date and time, to the consumer.

Forward Appeal to the Third-Party Contractor

The OLCRAH Processing Technician emails the Hearing/Appeal Request Form and the Hearing Notice, as a consolidated PDF document, to the CT Administrative Review email inbox for support processing by the third-party contractor.

Third-Party Contractor – Initial Administrative Processing

Receive Appeal from OLCRAH

The CT Administrative Review email inbox is monitored by assigned Appeals Support Unit staff.

The emails sent to the Appeals Support Unit include PDF attachments. A PDF attachment may include the documents for a single appeal or may include the documents for multiple appeals. It is common for multiple appeals to be included within a single email attachment.

Perform Initial Appeal Administration

Appeals Support Unit staff monitoring the email inbox perform the following administrative functions:

- They break the PDF attachment into separate PDF files so that each appeal document is now in a separate PDF.
- When the appeal is new, they create a new electronic folder for the appeal on a LAN drive.
- They save the PDF documents into the appeal folder on the LAN. The folder will include the Hearing/Appeal Request Form, the Hearing Notice, and any other documentation available and relevant to the appeal.
- When the appeal is new, they create an initial record for the appeal in the Appeals Tracker. The database record for an appeal provides a concise history of the appeal including its status and its scheduled hearing date.
- After all the information has been added into the Appeals Tracker and LAN folder:
    - An email is sent to the Appeals Supervisor alerting them of the new appeals that require assignment to an Appeals Coordinator.

- An email is sent to the Appeals Coordinator notifying them of any new documents received for one of their assigned appeals.

A consumer may attach supplementary information to an appeal form or may send supplementary information at a later point in time. The intent of this information is to (presumably) support the basis of their appeal. These supplementary documents should be stored with the appeal form. Sometimes these supplementary documents are a recognized work item (e.g., a paper application form or a verification document). It is not necessary to process these work-item type documents, i.e., do not copy/scan and redirect through the work item processing queues.

Assign the Appeal

Each morning the Appeals Supervisor notifies the Appeals Coordinators via email of the current/updated hearing schedule and a list of newly assigned appeals.

There is a requirement that the Hearing Summary Document be made available to both the consumer and the Hearing Officer at least five (5) days prior to the scheduled hearing date. Therefore, Appeals Coordinators must be continually aware of the status of all appeals they are responsible for, with special attention being given to hearing dates. Typically, the order of hearing dates defines the order in which the appeals are processed.

To reduce the instances where the five (5) day deadline is not met, Appeals Coordinators should create and maintain an action plan for the tasks, e.g., developing hearing documents, that require completion by close of business each day.

Third-Party Contractor – Appeal Processing Steps

Perform Preliminary Review & Research

The first step for the Appeals Coordinator in processing an appeal is to become familiar with the details. The Appeals Coordinator will review up to four information sources during this research phase:

- The Hearing/Appeal Request Form (see “Appendix A - Hearing/Appeal Request Form”). This form should contain a statement by the consumer setting forth why the consumer is appealing.

- The Hearing Notice. The hearing notice should also contain a statement on the central issue of the appeal, e.g., discontinuance of coverage.
- The HIX/Tier-1 system. The system has the application details, consumer history, consumer notices, enrollment dates and the actual determination reason with a citation to the specific regulation.
- The ImpaCT system. For some types of issues, research in the HIX/Tier-1 system will then lead to the need to confirm the alignment and promptness of coverage in the ImpaCT system.

It is important to note that often the consumer's issue as stated on the Hearing/Appeal Request Form may be ambiguous or incorrectly stated. Researching the consumer's application in the eligibility systems helps provide a better picture of the consumer's case.

With the above case information in hand, the Appeals Coordinator can begin to develop an informed "look down" into the appeal and broadly frame its nature, the facts underlying the appeal, and critically, the basis for the eligibility determination that was rendered.

Record the Factual Basis of a Decision

The Appeals Coordinator should use the information gathered in the prior research step to identify and clearly record the factual basis upon which the system based the adverse eligibility determination. This information will be used in the development of the Hearing Summary Document and in consumer discussions. For example:

- The date and ID of the application that was submitted.
- The critical data elements of the application such as (when relevant) the income, household size, tax filing status, other health coverage, etc.
- The detailed denial reason and referenced policy citation.

It is at this time that the Appeals Coordinator will likely be able to determine if there is a root cause that could lead to an early resolution and avoid a full appeal with a hearing. The document section "Guidance for Different Appeal Types and Scenarios" describes a number of types of issues that can lead to early resolution, e.g., a known system issue or a (likely) data entry issue.

It is also possible that at this point in the appeals process, the Appeals Coordinator determines that the appeal should be forwarded to Access Health Customer Service Department. The document section “Guidance for Different Appeal Types and Scenarios” describes a number of types of appeals that are outside of the DSS jurisdiction and that should be forwarded, e.g., an issue related to a failure to reconcile.

Review Initial Findings with the Consumer

After completing the preliminary review of a case and noting the critical details of the application, the Appeals Coordinator contacts the consumer via an outbound telephone call to confirm their issue, review their case and discuss the initial findings.

In some circumstances, this initial research step can allow the Appeals Coordinator to recommend how the appellant can resolve the issue and avoid the full appeals process. For example, the coordinator may determine that data was entered incorrectly (e.g., creditable health coverage wasn’t properly end-dated or removed and therefore resulting in a HUSKY B or APTC denial) or can simply explain the rules to the appellant. Resolving an appeal in this way is typically the best solution for the appellant and saves on administrative effort for the appellant and State. This step involves:

- Explaining to the consumer why they were found ineligible and/or advising the customer how to fix their issue, e.g., to go online and fix their application in a particular way. It is typically not the Appeals Support Unit’s job to fix issues directly (unless the State is at fault) as they acting in a legal support role; they are specifically not acting as an issue triage or customer service center.
- Advising the appellant how to withdraw their appeal if they are satisfied and only if the appellant wishes to do so. Refer to the “An Appellant Withdraws an Appeal” section for more information. If the consumer does withdraw the appeal the Appeals Coordinator should update the Appeals Tracker. The case is considered resolved if the appeal request is withdrawn.

The Appeals Coordinator must always permit the consumer to proceed to a hearing, even if the Appeals Coordinator believes that the consumer’s position is incorrect. The Appeals Coordinator may not say or do anything to interfere with the consumer’s right to a hearing.

When the consumer elects to proceed to the formal hearing stage the Appeals Coordinator should remind the consumer of the scheduled hearing date and that they will be mailed a copy of the Hearing Summary Document at least five (5) days prior to that date.

IMPORTANT NOTE ON RESOLUTIONS

Resolving the appeal involves explaining to the consumer any root-cause issue, and how it contributed to the eligibility determination. If the appellant made a mistake on their application or failed to submit documents, then that is the (correct) basis of the determination and this would be explained to the consumer.

It is typically not the job of the Appeals Support Unit to submit a new application for the appellant as other channels exist for that, i.e., resolution is strictly of the appeal itself, rather than serving as a type of customer support center**.** There are exceptions to this approach, such as when there is a known technical error in the eligibility system or a professional user made an error on data-entry. The document section "Guidance for Different Appeal Types and Scenarios" provides more details.

Third-Party Contractor – Prepare the Hearing Summary Document

General Guidance

The Hearing Summary Document is a critical artifact and it should be sent to both the Hearing Officer, with a copy to the appellant and any legal representative, at least five (5) days prior to the scheduled hearing date.

The Hearing Summary Document is addressed and written for the Hearing Officer and not the appellant; the appellant receives a (courtesy) copy.

The purpose of the Hearing Summary Document is to provide just enough information for the Hearing Officer to understand the composition of the household, the issue being appealed and the justification for the decision.

The Hearing Summary Document should NOT contain:

- Unnecessary information, e.g., if the appeal is about the calculated amount of APTCs then there is no need to contain information about irrelevant eligibility criteria such as citizenship or lawful presence.
- An unnecessary chronology of events. The focus is on the application/decision under appeal and not the various steps over time that are not directly pertinent to the issue under appeal.
- The use of technical jargon where it can be avoided.
- The use of acronyms are best avoided, but are (somewhat) permitted providing they are expanded on first use, denoting the acronym in parentheses, e.g. “Advanced Premium Tax Credit (APTC)”, after which “APTC” may be used.

Develop the Hearing Summary Document

There are a number of pre-developed templates that should be used in preparing a Hearing Summary Document. The Appeals Coordinator should select the most applicable template in preparing a particular Hearing Summary Document.

The use of template documents is intended to reduce the amount of time needed to develop a Hearing Summary Document, reduce the number of errors they contain, and provide for consistency.

Appendix D contains the existing common templates and models (worked examples). Over time, new templates and models can be developed to handle new or specialized scenarios. New or modified templates and models must be reviewed by OLCRAH prior to being included in Appendix D.

The Hearing Summary consists of a header section (pro-forma controls) followed by six (6) sections detailing the issue and the response:

1. Issue
2. Background
3. Relevant Facts
4. Summary of Actions

5. Relevant Regulations
6. Attachments

Writing Style Guide

The following is some basic guidance in writing style when completing a Hearing Summary:

1. The Hearing Summary document should read well from start-to-finish, i.e., the sections are for guidance and information should not be forced into the sections. If information does not help with clarity, is irrelevant for the issue or program at hand, or is repetitive then it should be excluded from the section. The task is to produce a concise, clear, relevant and holistic document and not to fill sections by rote.
2. Write in the voice of AHCT and DSS, i.e., do not refer to these organizations as if they are third party organizations.
3. When referring to the system refer to it as the Health Insurance Exchange (HIX), i.e., not AHCT or Access Health.
4. The HUSKY determinations should be represented as being made by the HIX system or the Department of Social Services (DSS).
5. The QHP/APTC/CSR determinations should be represented as being made by the HIX system or the AHCT, i.e., not the Department.
6. Limit facts to those that are directly pertinent to the issue being appealed.
7. Do not detail resolution attempts, i.e., just the pertinent facts of the appeal and not how the Appeals Support Unit may have tried to resolve the issue with the consumer.

Hearing Summary Sections

The Hearing Summary begins with a structured table that captures the identifying and control details of the appeal, e.g., the names of the assigned OLCRAH Hearing Officer, Appeals Coordinator and appellant, the mailing date, the hearing date and time, the application ID (if relevant), and the ImpaCT Client ID (if relevant). This section is standard and is laid out in the templates.

There are a further six sections, and they are as follows:

1. **Issue –** This section includes a concise statement setting forth unambiguously the subject of the appeal.

   The available templates are organized around the different types of issues. The stated issue typically corresponds to the "Issue and Reason for Action" sections of the Notice of Administrative Hearing unless further clarity was provided by the consumer during the research phase.

   Although typically dictated by the template, this section would otherwise begin with the verbiage:

   > "The issue is whether the Department correctly *{denied / reduced / calculated / discontinued / delayed}* …"

2. **Background –** This section is used to provide context and a brief summary of the scenario.

   This section could be considered as the "before-and-after" of the situation. For example:

   > *The household consisted of three people:*
   > *Fred Flintstone (the applicant)*
   > *Wilma Flintstone (the spouse of Fred)*
   > *Pebbles Flintstone (the child of Fred and Wilma Flintstone)*
   >
   > *The household members were initially enrolled in categories of HUSKY A.*
   >
   > *On 12/12/2013 Fred Flintstone reported a change of circumstances to the AHCT call center and this information was entered into the Health Insurance Exchange (HIX). The reported change included a change in the annual income and weekly employment income of Fred Flintstone. The household's new determination was as follows:*
   > *Fred Flintstone was determined eligible for QHP with APTCs*
   > *Wilma Flintstone was determined eligible for QHP*
   > *Pebbles Flintstone was determined eligible for HUSKY B – Band 1 (and QHP)*
   >
   > *Pebbles Flintstone was enrolled in HUSKY B – Band 1*

   It should be clear whether the scenario/action is:

   - A new application. Note that this can be either (a) a scenario where the individuals are previously unknown to the system (an "initial application" in the parlance of the HIX) or (b) an application for known individuals that have no

current coverage but had data in the system (incorrectly referred to as a type of "change application" in the parlance of the HIX).

- A self-reported change in circumstances.
- A self-reported change in circumstances during a renewal period.
- A worker case maintenance action such as an age-out determination, the ending of pregnancy coverage, etc.

3. **Relevant Facts –** This section documents the pertinent details that are the State's rationale for a correct determination, i.e., this is a determination-focused section. For example:

    - For a HUSKY income-related appeal (including a denial for APTCs because of eligibility for HUSKY), the relevant HUSKY income threshold, as a dollar amount, for the targeted HUSKY coverage category (parents/caretakers, adults, children, etc.) should be included.
    - For a failure to verify appeal the facts would be the date of the (1302) VCL notice, what it requested and the subsequent 90 day failure to verify. If there were documents that were submitted during that failed to verify the item in question then these could be noted along with the fact that an appropriate notice and calls were made.

    This section does not need to repeat the information in the Background section and can instead build off the context of the Background section.

4. **Summary of Actions –** This section summarizes the actions taken by the State, the reflection of those actions as an adherence to a prescribed statutory process and any additional rationale as necessary.

    This section does not need to repeat the information in the Background of Relevant Facts section and can instead build off the context of these sections.

    The actions should include the relevant notices generated by the shared HIX/Tier-1 system, along with the date on which each was sent to the appellant. If the notice cite (adverse) regulations that reflect the determination at issue then these should be noted.

The most common notices of interest to an appeal are eligibility related and include:

- 1301 notices – these are eligibility notices generated for initial applications, change reporting and manual renewals.
- 1302 notices – these are the verification notices, i.e., the start of the 90 day reasonable opportunity period (ROP) clock.
- 1326 notices – these are the termination of the 90-day ROP.
- 1305, 1605, 1606, 1607 and 1608 notices – these are the initiation notices for a HUSKY renewal.
- 1337 notices – these are the HUSKY finalization notices for the HUSKY renewal (auto approval or discontinuance). QHP logic will produce a variant of this notice once a year for the finalization of an auto-renewal.

5. **Relevant Regulations –** This section contains a summary of the relevant regulations.

   If the citations are documented in the prior section then it is preferable to reference that section, e.g., “See section 4 and the 1301 Eligibility notice of 12/12/2012”

6. **Attachments –** This section contains:

   - A copy of the OLCRAH Issued Notice of Administrative Hearing (w-3000fh).
   - A copy of the notice(s) relevant to the appeal (section 5 above provides guidance but is not absolute).
   - Relevant screenshots of the Eligibility Results and Enrollment Details sections from the shared HIX/Tier-1 system.
   - Optionally, a HIX/Tier-1 screenshot of the application summary if helpful.

   Copies of these notices and documents should also be saved in the consumer’s file on the local network drive by an Appeals Coordinator.

IMPORTANT NOTE

Appeals Coordinators must ensure that the data included in Hearing Summary is accurate. As such, they are required to proofread all sections and attachments, prior to sending out the Hearing Summary Document

Deliver the Hearing Summary Document

Upon its completion, the Hearing Summary Document is emailed to the assigned Hearing Officer and a copy mailed (US Postal Service) to the appellant and any legal representative. The mailing of the Hearing Summary Document to the Hearings Officer and appellant must be at least five (5) days prior to the scheduled hearing date.

Note that delivery to the assigned Hearing Officer should be by secured email, with a delivery receipt requested.

OLCRAH – Conduct the Hearing

If an appeal issue is not resolved (informally) during the preliminary review stage, a hearing is conducted on the scheduled date and time. The hearing is typically conducted over the phone, but, at the appellant's request, may be conducted by videoconference or in person. The Hearing Officer will open a bridge line and make it available for the appellant, as well as to the Appeals Support Unit, AHCT and DSS staff as appropriate.

IMPORTANT NOTE

The need for the Appeals Coordinator to support the hearing is under review and is expected to be phased out.

Appeals Process – Common Support Tasks and Responsibilities

OLCRAH – An Appellant Withdraws an Appeal

An appellant may conclude at any point in the Appeal process that a hearing is no longer necessary.

If the appellant makes the decision to withdraw their appeal prior to the start of the formal hearing, the Appeals Coordinator will facilitate a conference call with the OLCRAH Processing Technician and the appellant using the OLCHRAH Withdrawal Script, found in Appendix C. If the Hearing Officer cannot be reached, a voicemail is left on the Hearing Officer's telephone.

This conference call, whether the Hearing Officer is present telephonically or a voice mail is to be left, serves as the primary means of capturing the appellant's decision to withdraw the appeal. Because the appellant who makes this decision is foregoing their right to a hearing, the integrity of the overall appeals process is of paramount concern. To help ensure this integrity, it is important that a standard mechanism be used to facilitate the withdrawal of an appeal. By doing this, the possibility of a procedural misstep is reduced.

One means to help achieve this standardization is the use of structured call scripts when discussing with the appellant the decision to withdraw their appeal. Please refer to Appendix C for Outbound call scripts which should be used for various scenarios for appeals withdrawal.

After the conference call between the appellant, Hearing Officer, and the Appeals Coordinator, the OLCRAH Processing Technician sends a letter to the appellant. The appellant will sign the letter, confirming their decision to withdraw their appeal, and return the letter to OLCRAH.

If the Hearings Officer is not available, the appellant should be asked to confirm withdrawal in the voicemail. As above, the OLCRAH Processing Technician will follow up with a letter to the appellant.

Third-Party Contractor – Maintaining the Appeals Tracker Information

Once the initial database record is created in the Appeals Tracker, the Appeals Coordinator assigned to process a specific appeal is generally responsible for keeping the related database current throughout the lifecycle of the appeal.

The Appeals Coordinator should ensure each step/event in the processing of an appeal is noted in the Appeals Tracker, thereby helping ensure a comprehensive and centralized point of reference for each appeal.

There are several scenarios that require an Appeals Coordinator to update an existing, active record for an appellant in the Appeals Tracker. The Appeals Tracker record needs to be updated to include any activity related to the appeal. The notes should be as detailed as possible and completed on the same day as the tasks are performed. Notes in the Appeals Tracker should include the date, Appeals Coordinator's initials, issue with the appeals case and steps taken to perform the required tasks.

Some of the scenarios that require an update entry to the Appeals Tracker include:

- **Recording an Appeal Withdrawal**

  The Appeals Support Unit can be notified that an appeal has been withdrawn because the Appeals Coordinator is working directly with the consumer or because OLCRAH will notify the Appeal Coordinator via an email sent to CT Administrative Review Email inbox.

  The Appeals Support Unit is responsible to ensure the consumer's record in the Appeals Tracker reflects the information received. The database fields are also updated to reflect a resolved status, denoting whether the withdrawal was handled by the Appeals Coordinator with an OLCRAH Hearing Officer or directly through OLCRAH.

- **Updating a Hearing Date**

  Even though most appeals received from OLCRAH include the hearing notice, there are cases where the hearing details are provided a few days later in a separate email. When a hearing notice is received after the appeal, the database record must be updated with details such as the date, time, and officer designated for the hearing.

- **Updating a Reschedule**

  When an appellant reschedules a hearing, notification is provided to the Appeals Support Unit and the Appeals Coordinator updates the tracking information.

Third-Party Contractor – Adding Comments in the HIX/Tier-1 System

Minimally, on the first and last contact with an appellant during the appeals process, Appeals Coordinators are required to record case comments on the consumer's account in the HIX/Tier-1 system. Appeals Coordinators should record other case comments as appropriate, e.g., for each consumer contact. Case comments should include the following details:

- Shared HIX/Tier-1 System User ID
- Third-party contractor name
- The designation "Appeals"
- For the first contact note: "Hearing Appeal received for *(issue)*. Hearing is scheduled for *(date).*"
- For the terminating contact record, what was confirmed/changed on the consumer's application, the outcome and the appeal result.

Third-Party Contractor – Continuation of Coverage Pending Outcome

When an Appeals Coordinator receives an appeal in which the consumer has checked the box indicating they would like to request "Continuation of Coverage Pending Appeal Outcome"[1], that request is forwarded to the Appeals Supervisor for research and action.

The first check the Appeals Supervisor must make is whether the Hearing/Appeal Request Form is complete. "Complete" is defined as without a material omission. If a material omission exists, the Appeals Coordinator will work with the consumer to ensure the Appeal form is complete. Once the Hearing/Appeals Request Form is complete, the Appeals Coordinator will next research the consumer's recent and current Medicaid coverage groups in ImpaCT which is the eligibility system of record.

With the coverage information in hand, the Appeals Supervisor will look at the type of the consumer's HUSKY coverage type:

[1] When health insurance coverage is terminated or pending termination, consumers may request for an extension of coverage to remain active during the appeals process

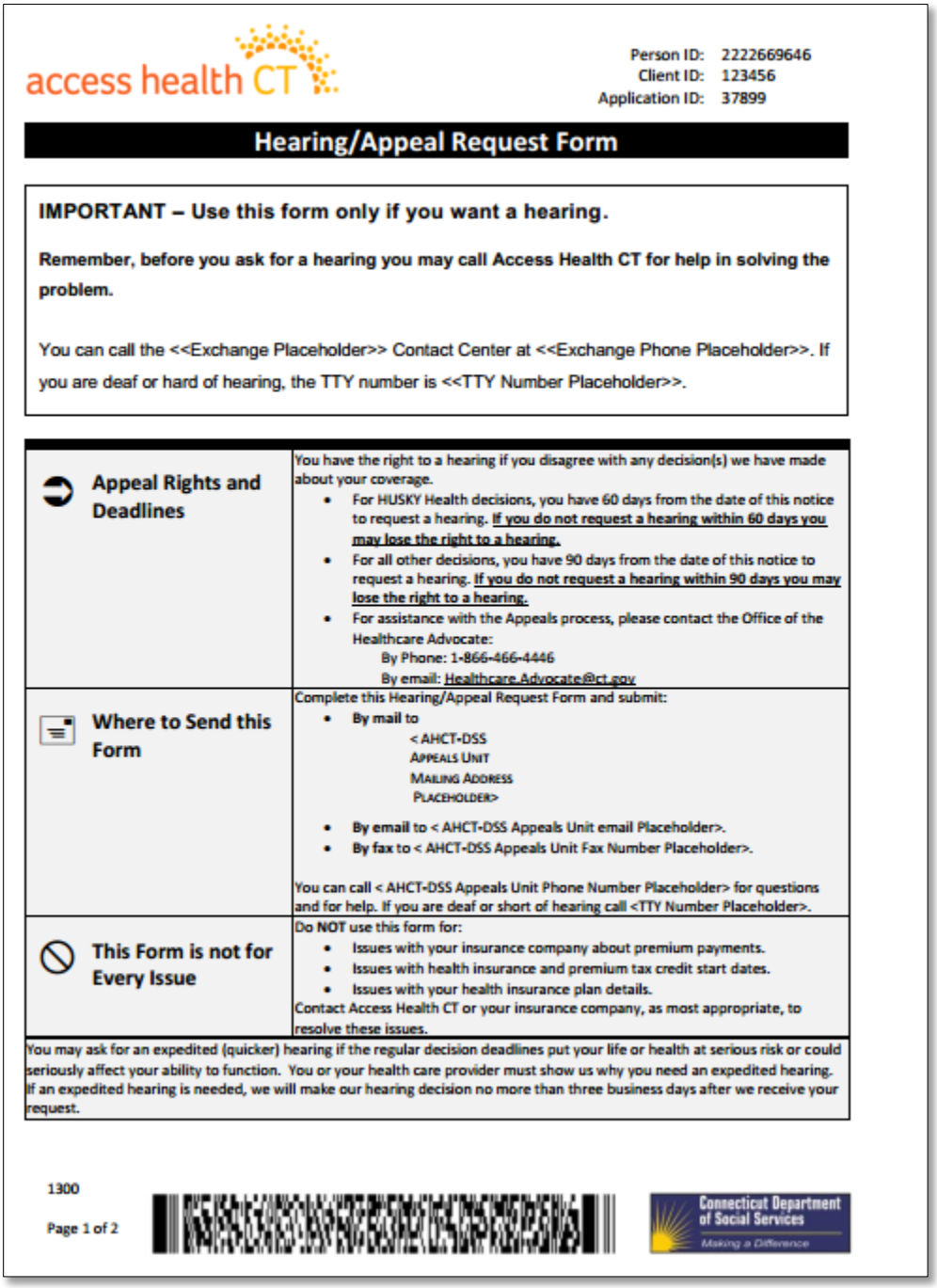
- If the HUSKY coverage type is **NOT** TMA (X03) the Appeals Supervisor will first determine whether the consumer's coverage has ended/closed/terminated. If it has not, the Appeals Supervisor will forward the request to the DSS Regional Hearings Liaison requesting the coverage be extended pending resolution of the appeal request.

  If the coverage has already ended, the Appeals Supervisor will then look to see whether timely notice of the adverse eligibility determination was provided to the consumer. The consumer will normally have received a timely notice unless there was a system or printing issue. If the consumer was provided with a timely notice, the Request for Continuation of Coverage should be denied. If, in an exception scenario, the consumer was not provided a timely notice the Appeals Supervisor will forward the request to the DSS Regional Hearings Liaison asking that the coverage be extended pending resolution of the appeal request.

- If the coverage type is TMA (X03), the Appeals Supervisor will then determine whether that coverage ended after a full year or was discontinued due to a change in circumstance, e.g., a child turns 19 years old, the child moved out of the household or an individual moved out of State. If the coverage ended after a full year of benefits then the coverage cannot be extended. If the coverage ended early due to a change in circumstances then the same rules and process applies as the non-TMA HUSKY coverage.

Appendix A – Hearing/Appeal Request Form

This appeals form is included as an attachment to eligibility notices and available for download. This form is subject to change and included here for convenience, i.e., the form could change and not be updated in this document.



access health CT

Person ID: 2222669646
Client ID: 123456
Application ID: 37899

Hearing/Appeal Request Form

IMPORTANT – Use this form only if you want a hearing.

Remember, before you ask for a hearing you may call Access Health CT for help in solving the problem.

You can call the <<Exchange Placeholder>> Contact Center at <<Exchange Phone Placeholder>>. If you are deaf or hard of hearing, the TTY number is <<TTY Number Placeholder>>.

Appeal Rights and Deadlines	You have the right to a hearing if you disagree with any decision(s) we have made about your coverage. • For HUSKY Health decisions, you have 60 days from the date of this notice to request a hearing. **If you do not request a hearing within 60 days you may lose the right to a hearing.** • For all other decisions, you have 90 days from the date of this notice to request a hearing. **If you do not request a hearing within 90 days you may lose the right to a hearing.** • For assistance with the Appeals process, please contact the Office of the Healthcare Advocate: By Phone: 1-866-466-4446 By email: Healthcare.Advocate@ct.gov
Where to Send this Form	Complete this Hearing/Appeal Request Form and submit: • **By mail** to < AHCT-DSS APPEALS UNIT MAILING ADDRESS PLACEHOLDER> • **By email** to < AHCT-DSS Appeals Unit email Placeholder>. • **By fax** to < AHCT-DSS Appeals Unit Fax Number Placeholder>. You can call < AHCT-DSS Appeals Unit Phone Number Placeholder> for questions and for help. If you are deaf or short of hearing call <TTY Number Placeholder>.
This Form is not for Every Issue	Do **NOT** use this form for: • Issues with your insurance company about premium payments. • Issues with health insurance and premium tax credit start dates. • Issues with your health insurance plan details. Contact Access Health CT or your insurance company, as most appropriate, to resolve these issues.

You may ask for an expedited (quicker) hearing if the regular decision deadlines put your life or health at serious risk or could seriously affect your ability to function. You or your health care provider must show us why you need an expedited hearing. If an expedited hearing is needed, we will make our hearing decision no more than three business days after we receive your request.

1300

Page 1 of 2

Connecticut Department of Social Services
Making a Difference

Person ID: 2222669646
Client ID: 123456
Application ID: 37899

Step 1 Tell us about yourself

1. Name *(first middle last suffix)*

2. Mailing address | 3. Apartment or Suite Number

4. City | 5. State | 6. ZIP code

7. Daytime phone number | 8. Email address

9. Will you need a translator at the hearing? ☐ Yes ☐ No *If yes,* what language do you speak?

10. We usually hold hearings by telephone. You may also have a hearing by video conference from a DSS regional office. Please check how you want your hearing? ☐ By telephone ☐ By video conference at DSS

Step 2 Tell us what you wish to appeal

☐ I disagree with the decision to deny or end HUSKY Health (Medicaid or CHIP) coverage.

☐ I disagree with the decision about financial help with paying for my health insurance plan (includes decision to deny or end this help and decisions on the amount of help).

Financial assistance is for health insurance plans and can include premium tax credits and lower cost sharing such as co-pays and deductibles.

☐ I disagree with the denial to buy a health insurance plan.

☐ Any other reason or if you want to give more details – ***please explain***:

HUSKY Only: If you were getting HUSKY medical benefits and you ask for a hearing about the decision **any time before the change becomes effective**, your medical benefits will stay as they were until the Hearing Officer decides your case.

☐ **Please check this box if you want to keep your health care coverage** the way it was before the Access Health CT decision and until the Hearing Officer decides your case. **IF YOU CHOOSE TO KEEP YOUR COVERAGE UNTIL THE HEARING AND THE HEARING OFFICER DECIDES THAT WE WERE RIGHT, YOU MAY HAVE TO PAY BACK ANY MEDICAL ASSISTANCE YOU GOT WHILE YOU WERE WAITING FOR THE HEARING DECISION.**

Step 3 Read and sign this form

Is someone helping you with this appeal? (For example, this could be a friend, family member, an attorney, someone else)
☐ Yes ☐ No. *If yes,* please provide this person's contact information:

Name

Address

Phone | Email

Signature of applicant or authorized representative: **Date *(mm/dd/yyyy)*:**

1300

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HUSKY HEALTH CONNECTICUT

HUSKY HEALTH CONNECTICUT

Appendix B – List of Regional DSS Offices

- Bridgeport Field Office - 925 Housatonic Avenue, Bridgeport, CT 06606-5700
- Danbury Field Office - 342 Main Street, Danbury, CT 06810-5833
- Greater Hartford Field Office - 20 Meadow Road, Windsor, CT 06095
- Manchester Field Office - 699 Middle Turnpike East, Manchester, CT 06040-3744
- Middletown Field Office - 2081 South Main Street (Route 17), Suite B, Middletown, CT 06457
- New Britain Field Office - 30 Christian Lane, New Britain, CT 06051-4121
- New Haven Field Office - 50 Humphrey Street, New Haven CT, 06513-2905
- Norwich Field Office - 401 West Thames Street, Unit 102, Norwich, CT 06360
- Stamford Field Office - 1642 Bedford Street, Stamford, CT 06905-4731
- Torrington Field Office - 62 Commercial Boulevard, Suite 1, Torrington, CT 06790-9983
- Waterbury Field Office - 249 Thomaston Ave., Waterbury, CT 06702-1397
- Willimantic Field Office - 676 Main Street, Willimantic, CT 06226

Appendix C – Outbound Call Scripts

Standard Opening Script

"Hi, my name is _____. I am calling from Access Health CT. Is _____ available?"

"Hi, _____. I am calling regarding your appeal of the eligibility determination made in your case. Do you have a few minutes to go over your information?"

"Before we move forward, I do need to verify some information for security purposes. May I have your date of birth and the last four digits of your social security number?"

Standard Voicemail Script

"Hi, this message is for _____. This is _____ and I am calling from Access Health CT regarding your medical appeal. Please call me on my direct line at 860-282-xxxx as soon as possible. Thank you."

OLCRAH Withdraw Script

Once OLCRAH Hearing Office is reached:

"This is _____ from _____ (name of the Contractor) and I have a withdrawal. The last name is _____ and the first _____. The hearing request # is _____.
"

When OLCRAH Processing Technician is ready, Appeals Coordinator will click Join to conference in the consumer:

"(consumer's name), I have OLCRAH on the line. Please state your name and that you want to cancel your appeal hearing."

OLCRAH Withdraw Script – Voicemail

Before conferencing the consumer, Appeals Coordinator will begin voicemail with the following:

"This is _____ from _____ (Name of the Contractor) and I have a withdrawal. The last name is _____ and the first _____. The hearing request # is _____."

Click Join to conference in the consumer:

"(consumer's name), we are going to leave a message. Please state your name and that you want to cancel your appeal hearing."

Inform consumer that OLCRAH will send a hearing cancelation confirmation letter that needs to be signed and returned.

Appendix D – Hearing Summary Templates and Models

As new approved templates or models (worked examples) are created they will be added to this document section. New or updated templates and models would be considered a minor release and could be approved by OLCRAH alone.

Basic Template

This template is the most basic outline and should only be used when there isn't a more specific template or model available.


Hearing Summary Template - Basic.doc

State of Connecticut
Department of Social Services

Hearing Summary

To: <hearing officer name>
Administrative Hearings, Central Office
From: <appeals coordinator name>
Appeals Coordinator,
Fair Hearing Liaison, Regional Office

Date: <mm/dd/yyyy>

Regarding:
Case Name: <appellant full name>
Hearing Date: <mm/dd/yyy>
Application ID: <nnnnnnnnn>
Client ID: <00nnnnnnn>

1. Issue

<Concisely summarize the issue of the appeal>

2. Background

<Provide any relevant background>

3. Relevant Facts

<Provide any relevant facts in chronological order (when applicable)>

4. Summary of Actions

<Provide details on the departments actions in chronological order>

copy: <appellant full name>

5. Relevant Regulations

<Cite regulations or legislature pertinent to the decision>

6. Attachments

The following attachments are provided:

1. Notification of Administration Telephone Hearing Notice
2. Hearing/Appeal Form
3. <Notices>
4. <Notices>
5. <Notices>
6. Eligibility Determination Results – screenshot
7. Enrollment Details – screenshot
8. Application Summary – screenshot

Model-1: Loss of HUSKY due to an Increase in Income

Hearing Summary

To: Arthur Dent
Administrative Hearings, Central Office

Date: 01/22/2013

From: Bill Smith
Appeals Coordinator,
Fair Hearing Liaison, Regional Office

Regarding:
Case Name: Fred Flintstone
Hearing Date: 02/14/2013
Application ID: 101010101
Client ID: 001234567

1. Issue

The issue is whether the Department correctly discontinued HUSKY A coverage for Fred Flintstone and his spouse Wilma Flintstone while continuing HUSKY A coverage for their daughter Pebbles Flintstone.

2. Background

The application and household consisted of three people:

- Fred Flintstone (the primary applicant)
- Wilma Flintstone (the spouse of Fred Flintstone)
- Pebbles Flintstone (the child of Fred and Wilma Flintstone)

The household members were initially enrolled in categories of HUSKY A coverage.

On 12/12/2013 Fred Flintstone reported a change of circumstances to the AHCT call center and this information was entered into the Health Insurance Exchange (HIX) system. The reported change included a change in the annual income and weekly employment income of Fred Flintstone. The household's new determination was as follows:

- Fred Flintstone was determined eligible for a qualified health plan (QHP) with advanced premium tax credits (APTCs).
- Wilma Flintstone was determined eligible for QHP.
- Pebbles Flintstone was determined eligible for HUSKY A for Children.

Fred and Wilma did not enroll in a QHP.

copy: <appellant full name>

Pebbles Flintstone remained enrolled in HUSKY A.

3. Relevant Facts

In December 2013, the relevant Connecticut monthly income thresholds for a family of three (3) were as follows:

- $XXXXXX (155% of FPL) for *HUSKY A – Parents & Caretakers* coverage.
- $XXXXXX (201% of FPL) for *HUSKY A – Children* coverage.

Prior to the 12/12/2013 reported change, the monthly household income was $XXXXXX and the family was eligible and enrolled in HUSKY A coverage.

On 12/12/2013 there was a reported increase in employment income and the total countable monthly household income was determined as $XXXXX. (Note that monthly income is calculated by multiplying a representative weekly income by 4.3. Citation: Connecticut UPM 5025.05(B)(2)).

The updated monthly income amount was greater than the *HUSKY A – Parents & Caretakers* monthly income threshold and so the HUSKY A coverage of Fred and Wilma Flintstone was discontinued.

Fred and Wilma Flintstone were not eligible for Transitional Medical Assistance (TMA) as they had pending income verifications, i.e., they had not qualified their original income prior to reporting the change in income.

4. Summary of Actions

- On 12/12/2013, Fred Flintstone contacted the AHCT call center and reported a change in his weekly employment income. This data was correctly entered by the call center representative.
- On 12/12/2013, the HIX system generated and sent a *1301 Eligibility and Enrollment* notice to Fred Flintstone. A copy was also sent to Barney Rubble as their Authorized Representative.
- The *1301 Eligibility and Enrollment* notice correctly provided the following HUSKY denial reason and citation:

Fred Flintstone [you] and **Wilma Flintstone** do not qualify for *HUSKY A – Parents & Caretakers* because they are in a household with $nnnnn of monthly income. The income limit for a household size of 3 is $mmmm. We used this rule: 42 CFR 435.110.

- The *1301 Eligibility and Enrollment* notice correctly provided a coverage end date for Fred and Wilma's current HUSKY A enrollment of 12/31/2013, i.e., greater than 10-days of notice for the adverse action.

5. Relevant Regulations

Fred and Wilma Flintstone were considered for HUSKY A using the federal regulation for parents and caretaker relatives: 42 CFR 435.110.

Fred and Wilma Flintstone were also considered for Transitional Medical Assistance using the 42 United States Code Section 1396r-6(a)(1) and Connecticut General Statutes Section 17b-261(f).

6. Attachments

The following attachments are provided:

1. Notification of Administration Telephone Hearing Notice
2. Hearing/Appeal Form
3. 1301 Eligibility and Enrollment notice of 12/12/2013
4. Eligibility Determination Results – screenshot
5. Enrollment Details – screenshot
6. Application Summary – screenshot