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

[redacted] **2016**
Signature Confirmation

Client ID # [redacted]
Application # [redacted]
Hearing Request # 792420

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2016, the Health Insurance Exchange Access Health CT ("AHCT") sent [redacted], (the "Appellant") a notice discontinuing her HUSKY A Medicaid for Parents and Caretakers effective [redacted]/16 for failure to provide verification within 90 days.

On [redacted] 2016, The Appellant requested a hearing to contest the discontinuance of Medicaid.

On [redacted] 2016, the Office of legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2016.

On [redacted] 2016, in accordance with sections 17b-60, 17b-264 and 4-176e to 4-189, inclusive, of the Connecticut General Statutes, chapter 45 Code of Federal Regulations ("CFR") §§ 155.505(b) and 155.510 and/or 42 CFR § 457.1130, OLCRAH held an administrative hearing. The following individuals were present at the hearing:

[redacted] Appellant
Karen Cossu, Access Health CT Representative
Marci Ostroski, Hearing Officer

The hearing record was left open for the submission of additional evidence. Evidence was received from AHCT and the hearing record closed [redacted] 2016.

STATEMENT OF THE ISSUE

The issue to be decided is whether Access Health CT correctly discontinued HUSKY A Medicaid for failure to provide 90 day verification.

FINDINGS OF FACT

1. On [redacted] 2016 the Appellant submitted a change reporting application for healthcare assistance. (Ex. 9: Application [redacted]

2. The Appellant's household consists of herself, her spouse, and her child. This is a household of three. (Ex. 9: Application [redacted]

3. The Appellant self-attested gross monthly household income of $1600 on her [redacted] 2016 application (Ex. 9: Application [redacted] Appellant's testimony, AHCT testimony).

4. On [redacted] 2016, AHCT sent the Appellant a notice requesting current proof of the Appellant's monthly income within 10% of what was reported on her application. The due date for information was [redacted] 2016 and stated that if information was not received the Medicaid would close effective [redacted]/16. (Ex. 10: Additional Verification Required notice, [redacted]/16).

5. On [redacted] 2016, AHCT sent the Appellant another notice requesting current proof of the Appellant's monthly income within 10% of what was reported on her application. The due date for information was [redacted] 2016 and stated that if information was not received the Medicaid would close effective [redacted]/16 (Ex. 1: Reminder-Additional Documents Needed notice, [redacted]/16).

6. On [redacted] 2016, AHCT sent the Appellant another notice requesting current proof of the Appellant's monthly income within 10% of what was reported on her application. The due date for information was [redacted] 2016 and stated that if information was not received the Medicaid would close effective [redacted]/16 (Ex. 2: Reminder-Additional Documents Needed Notice, [redacted]/16)

7. On [redacted] 2016 AHCT received wage stubs for the Appellant's spouse dated [redacted] 2016, [redacted] 2016, [redacted] 2016, and [redacted] 2016 showing gross monthly income of $4698.95 (1035.83 + 1157.71 + 1118.74 + 1058.84 = 4371.12 / 4 * 4.3) with a deduction for 401K disbursements of 837.12 (184.63 + 206.14+199.26+188.69=778.72/4*4.3). (AHCT testimony, Ex. 11: Wage Stubs)

8. On [redacted] 2016 AHCT reviewed the documents and determined that the wage stubs were not current as they were over 60 days old. AHCT sent the Appellant a Verification Failed letter requesting current proof of the Appellant's monthly income within 10% of what was reported on her application. The new due date for information was [redacted] 2016 and stated that if information was not received the Medicaid would close effective [redacted]/16. (AHCT testimony, Ex. 5: Verification Failed Notice, [redacted]/16)

9. On [redacted] 2016, AHCT sent the Appellant a 90 Day Final Determination Notice notifying the Appellant that her HUSKY A Medicaid for Parents and Caretakers would be discontinued on [redacted] 2016 (Ex.4: 90 Day Final Determination Notice, [redacted]/16).

10. On [redacted] 2016 AHCT offered to submit a new application for the Appellant with the wage stubs from [redacted] 2016. The Appellant declined. (AHCT testimony)

CONCLUSIONS OF LAW

1. Section 17b-260 of the Connecticut General Statutes ("CGS") provides for acceptance of federal grants for medical assistance**.** The Commissioner of Social Services is authorized to take advantage of the medical assistance programs provided in Title XIX, entitled "Grants to States for Medical Assistance Programs", contained in the Social Security Amendments of 1965 and may administer the same in accordance with the requirements provided therein, including the waiving, with respect to the amount paid for medical care, of provisions concerning recovery from beneficiaries or their estates, charges and recoveries against legally liable relatives, and liens against property of beneficiaries.

2. Section 17b-264 of the CGS provides for the extension of other public assistance provisions**.** All of the provisions of sections 17b-22, 17b-75 to 17b-77, inclusive, 17b-79 to 17b-83, inclusive, 17b-85 to 17b-103, inclusive, and 17b-600 to 17b-604, inclusive, are extended to the medical assistance program except such provisions as are inconsistent with federal law and regulations governing Title XIX of the Social Security Amendments of 1965 and sections 17b-260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, and 17b-357 to 17b-361, inclusive.

3. Title 45 of the Code of Federal Regulations ("CFR") § 155.505(c)(1) provides that Exchange eligibility appeals may be conducted by a State Exchange appeals entity or an eligible entity described in paragraph (d) of this section that is designated by the Exchange, if the Exchange establishes an appeals process in accordance with the requirements of this subpart.

4. 45 CFR § 155.505(d) provides that an appeals process established under this subpart must comply with § 155.110(a).

5. 45 CFR § 155.110(a)(2) 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: the State Medicaid agency, or any other State agency that meets the qualification of paragraph (a)(1) of this section.

6. 42 CFR § 435.952 provides for: use of information and requests of additional information from individuals.
   (a) The agency must promptly evaluate information received or obtained by it in accordance with regulations under §435.940 through §435.960 of this subpart to determine whether such information may affect the eligibility of an individual or the benefits to which he or she is entitled.

   (b) If information provided by or on behalf of an individual (on the application or renewal form or otherwise) is reasonably compatible with information obtained by the agency in accordance with §435.948, §435.949 or §435.956 of this subpart, the agency must determine or renew eligibility based on such information.

   (c) An individual must not be required to provide additional information or documentation unless information needed by the agency in accordance with §435.948, §435.949 or §435.956 of this subpart cannot be obtained electronically or the information obtained electronically is not reasonably compatible, as provided in the verification plan described in §435.945(j) with information provided by or on behalf of the individual.

   (1) Income information obtained through an electronic data match shall be considered reasonably compatible with income information provided by or on behalf of an individual if both are either above or at or below the applicable income standard or other relevant income threshold.

   (2) If information provided by or on behalf of an individual is not reasonably compatible with information obtained through an electronic data match, the agency must seek additional information from the individual, including—

   (i) A statement which reasonably explains the discrepancy; or

   (ii) Other information (which may include documentation), provided that documentation from the individual is permitted only to the extent electronic data are not available and establishing a data match would not be effective, considering such factors as the administrative costs associated with establishing and using the data match compared with the administrative costs associated with relying on paper documentation, and the impact on program integrity in terms of

the potential for ineligible individuals to be approved as well as for eligible individuals to be denied coverage;

(iii) The agency must provide the individual a reasonable period to furnish any additional information required under paragraph (c) of this section.

(d) The agency may not deny or terminate eligibility or reduce benefits for any individual on the basis of information received in accordance with regulations under §435.940 through §435.960 of this subpart unless the agency has sought additional information from the individual in accordance with paragraph (c) of this section, and provided proper notice and hearing rights to the individual in accordance with this subpart and subpart E of part 431.

7. 45 CFR § 155.320 (B) provides for the verification process related to eligibility for insurance affordability programs; If the identifying information for one or more individuals does not match a tax record on file with the Secretary of the Treasury that may be disclosed in accordance with section 6103(l)(21) of the Code and its accompanying regulations, the Exchange must proceed in accordance with §155.315(f)(1).

8. 45 CFR §155.320(c)(2)(B)(ii) provides for the verification process for Medicaid and CHIP for MAGI based household income; The Exchange must verify MAGI-based income, within the meaning of 42 CFR 435.603(d), for the household described in paragraph (c)(2)(i) in accordance with the procedures specified in Medicaid regulations 42 CFR 435.945, 42 CFR 435.948, and 42 CFR 435.952 and CHIP regulations at 42 CFR 457.380.

9. 45 CFR§ 155.320(c)(3)(vi)(E) If, following the 90-day period described in paragraph (c)(3)(vi)(D) of this section, an applicant has not responded to a request for additional information from the Exchange and the data sources specified in paragraph (c)(1) of this section indicate that an applicant in the tax filer's family is eligible for Medicaid or CHIP, the Exchange must not provide the applicant with eligibility for advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP or the BHP, if a BHP is operating in the service area of the Exchange

10. 45 CFR §155.320(c)(3)(vi)(D) provides for *Decreases in annual household income and situations in which electronic data is unavailable.* If electronic data are unavailable or an applicant's attestation to projected annual household income, as described in paragraph (c)(3)(ii)(B) of this section, is more than ten percent below the annual household income as computed using data sources described in paragraphs (c)(3)(vi)(A) of this section, the Exchange must follow the procedures specified in §155.315(f)(1) through (4)

11. 45 CFR § 155.315(f)(1)(2) provides for the verification process related to eligibility for enrollment in a QHP through the Exchange, except as otherwise

specified in this subpart, for an applicant for whom the Exchange cannot verify information required to determine eligibility for enrollment in a QHP through the Exchange, advance payments of the premium tax credit, and cost-sharing reductions, including when electronic data is required in accordance with this subpart but data for individuals relevant to the eligibility determination are not included in such data sources or when electronic data from IRS, DHS, or SSA is required but it is not reasonably expected that data sources will be available within 1 day of the initial request to the data source, the Exchange:

(1) Must make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the application filer to confirm the accuracy of the information submitted by the application filer;
(2) If unable to resolve the inconsistency through the process described in paragraph (f)(1) of this section, must—
    (i) Provide notice to the applicant regarding the inconsistency; and
    (ii) Provide the applicant with a period of 90 days from the date on which the notice described in paragraph (f)(2)(i) of this section is sent to the applicant to either present satisfactory documentary evidence via the channels available for the submission of an application, as described in §155.405(c), except for by telephone through a call center, or otherwise resolve the inconsistency.

12. AHCT correctly determined that the Appellant self-attested income was more than 10% below the income as computed using outside data sources.

13. The acceptable threshold of error on the self-attested income would be equal to 10% above or below the $1600.00 per month the Appellant reported or $1440.00-$1760.00.

14. 45 CFR § 155.310 (K) (1)(2)(3)pertains to an incomplete application. If an application filer submits an application that does not include sufficient information for the Exchange to conduct an eligibility determination for enrollment in a QHP through the Exchange or for insurance affordability programs, if applicable, the Exchange must –
(1) Provide notice to the applicant indicating that information necessary to complete an eligibility determination is missing, specifying the missing information, and providing instructions on how to provide the missing information; and
(2) provide the applicant with a period of no less than 10 days and no more than 90 days from the date on which the notice described in paragraph (k)(1) of this section is sent to the applicant to provide the information needed to complete the application to the Exchange. And
(3) During the period described in paragraph (k)(2) of this section, the Exchange must not proceed with an applicant's eligibility determination or provide advance payments of the premium tax credit or cost sharing reductions, unless an

application filer has provided sufficient information to determine his or her eligibility for enrollment in a QHP through the Exchange , in which case the Exchange must make such a determination for enrollment in a QHP.

15. 42 CFR 457.380(d) provides for the eligibility process: *Income.* If the State does not accept self-attestation of income, the State must verify the income of an individual by using the data sources and following standards and procedures for verification of financial eligibility consistent with §435.945(a), §435.948 and §435.952 of this chapter

16. 42 CFR 457.380(j) *Verification plan.* The State must develop, and update as modified, and submit to the Secretary, upon request, a verification plan describing the verification policies and procedures adopted by the State to implement the provisions set forth in this section in a format and manner prescribed by the Secretary.

17. AHCT correctly issued notices to the Appellant that requested additional documents within 90 days to validate eligibility for healthcare coverage.

18. AHCT correctly determined that the Appellant did not submit current verification of income within the 10% margin of error within 90 days

19. AHCT correctly discontinued the HUSKY A Medicaid for failure to provide requested information within 90 days.

DISCUSSION

AHCT's action to discontinue the Appellant's HUSKY A Medicaid for failure to provide information is upheld. The Appellant was given 90 days to provide AHCT with current verification that her monthly gross income was within 10% of the $1600 she reported on the application. AHCT requested proof of annual income from the Appellant on three separate occasions and she failed to provide current verification within 90 days that the household's income was within 10% of $1600.

This decision does not address AHCT's manual recalculation of the Appellant's income from [redacted] The Appellant declined to submit a new application with the household's actual verified income so the issue to be adjudicated stands at the 90 day discontinuance for failure to provide information.

DECISION

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

Marci Ostroski
Hearing Officer

Pc: Karen Cossu, Judy Boucher, Health Insurance Exchange Access Health CT

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

MEDICAID AND 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.

There is no right to request reconsideration for denials or reductions of Advanced Premium Tax Credits (APTC) or Cost Sharing Reduction (CSR).

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, 55 Elm Street, 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.