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

[REDACTED] 2017
Signature Confirmation

Client ID # [REDACTED]
Application # [REDACTED]
Hearing Request # 804696

NOTICE OF DECISION

PARTY

[REDACTED]
[REDACTED]
[REDACTED]

PROCEDURAL BACKGROUND

On [REDACTED] 2016, the Health Insurance Exchange Access Health CT ("AHCT") sent [REDACTED], (the "Appellant") a notice discontinuing HUSKY A Medicaid for her household effective [REDACTED] 2016 due to her failure to verify her household's income.

On [REDACTED] [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] [REDACTED] 2017.

On [REDACTED] 2017, at the Appellant's request, OLCRAH issued a notice rescheduling the hearing for [REDACTED] 2017.

On [REDACTED] 2017, 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, via telephone

Debra Henry, AHCT Representative, via telephone
James Hinckley, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT was correct when it discontinued the Appellant's HUSKY A Medicaid.

FINDINGS OF FACT

1. The Appellant's household includes herself, her spouse, and a dependent minor child. (Hearing Record, Appellant testimony)

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

3. The income reported for the Appellant's household as of the date of her [redacted] 2016 application was different from the income reflected on any tax return filed by the Appellant for any previous year; prior years' tax returns did not reflect that as of [redacted] 2016, the Appellant's spouse was no longer working for his former employer, but was instead now self-employed as a business owner. (Appellant testimony)

4. The Appellant's household's income could not be verified through tax return data from prior years, or through electronic data matching, because no electronic records were available that reflected the self-employment business income. (Hearing Record).

5. On [redacted] 2016, AHCT sent the Appellant a notice requesting that she provide at least one of a list of acceptable documents verifying self-employment income to AHCT by no later than [redacted] 2016 in order to determine the household's eligibility for the HUSKY A for Parents and Caretakers program; the notice further advised her that she could submit the documents either online or through the mail, and that as regards Medicaid, the Appellant would lose eligibility on [redacted] 2016 if she did not provide the documents. (Ex. 2: Additional Verification Required notice, [redacted]/16).

6. On [redacted] 2016, AHCT sent the Appellant a second notice requesting that she provide at least one of a list of acceptable documents verifying self-employment income to AHCT by no later than [redacted] 2016 in order to determine the household's eligibility for the HUSKY A for Parents and Caretakers program; the notice further advised her that she could submit the documents either online or through the mail, and that as regards Medicaid, the Appellant

would lose eligibility on ████████ 2016 if she did not provide the documents. (Ex. 3: Reminder – Additional Documents Needed notice, ███/16).

7. On ████████ 2016, AHCT sent the Appellant a third notice requesting that she provide at least one of a list of acceptable documents verifying self-employment income to AHCT by no later than ████████ 2016 in order to determine the household's eligibility for the HUSKY A for Parents and Caretakers program; the notice further advised her that she could submit the documents either online or through the mail, and that as regards Medicaid, the Appellant would lose eligibility on ████████ 2016 if she did not provide the documents. (Ex. 4: Reminder – Additional Documents Needed notice, ███/16)

8. The Appellant planned on providing AHCT with her 2015 tax return, which was not filed until ████████ 2016, but she did not send it because she had difficulty setting up an account on the AHCT web site to submit the document electronically, and had concerns about sending sensitive tax information through the mail to the address provided by AHCT. (Appellant testimony)

9. The 2015 tax return was not one of the acceptable types of documentation to verify self-employment that were listed on the three notices sent to the Appellant; the acceptable types of documentation listed were: Business records showing income after allowable deductions, Recent/Quarterly tax returns, Statement of Projected Earnings, and Your most recent 1099-MISC. (Ex. 2, Ex. 3, Ex. 4)

10. The Appellant did not provide AHCT with her tax return, or with any of the acceptable documents by the ████████ 2016 due date. (Hearing Record, Appellant testimony)

11. On ████████ 2016, AHCT sent the Appellant a notice advising her of the loss of HUSKY health coverage for her household effective ████████ 2016 because she did not send the documents needed to prove her household's monthly income. (Ex. 5: Important – Your Health Coverage is Ending notice, ███/16)

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. 45 CFR §155.305(c) *Eligibility for Medicaid.* The Exchange must determine an applicant eligible for Medicaid if he or she meets the non-financial eligibility criteria for Medicaid for populations whose eligibility is based on MAGI-based income, as certified by the Medicaid agency in accordance with 42 CFR 435.1200(b)(2), has a household income, as defined in 42 CFR 435.603(d), that is at or below the applicable Medicaid MAGI-based income standard as defined in 42 CFR 435.911(b)(1) and –

   (1) Is a pregnant woman, as defined in the Medicaid State plan in accordance with 42 CFR 435.4;
   (2) Is under age 19;
   (3) Is a parent or caretaker relative of a dependent child, as defined in the Medicaid State plan in accordance with 42 CFR 435.4; or
   (4) Is not described in paragraph (c)(1), (2), or (3) of this section, is under age 65 and is not entitled to or enrolled for benefits under part A of title XVIII of the Social Security Act, or enrolled for benefits under part B of title XVIII of the Social Security Act.

7. 45 CFR § 155.320 Verification process related to eligibility for insurance affordability programs (c) *Verification of household income and family/household size*-- (2) *Verification process for Medicaid and CHIP* (ii) *Verification process 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…

8. 42 CFR § 435.952 discusses use of information and requests of additional information from individuals, and provides as follows:

(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.

9. AHCT was correct to require the Appellant to provide additional documentation regarding her household's income from self-employment, because the information was necessary in order to make an eligibility determination for an insurance affordability program and the information could not have been otherwise obtained through electronic means.

10. 45 CFR § 155.310 (k) *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.

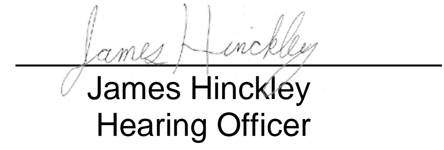
11. AHCT provided proper notice to the Appellant of what missing information it needed in order to make an eligibility determination, and the notices sent to the Appellant included instructions on how to provide the missing information.

12. AHCT provided the Appellant with a reasonable period of time, as required pursuant to 45 CFR § 155.310(k)(2), to provide the missing information.

13. AHCT was correct when, on [redacted] 2016, it discontinued the Appellant's HUSKY A Medicaid effective [redacted] 2016, due to her failure to provide, by the due date, the missing information needed to make an eligibility determination on her case.

DECISION

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



James Hinckley
Hearing Officer

cc: Judy Boucher, 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.