

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

██████████ 2017
Signature Confirmation

Client ID # ██████████
Application # ██████████
Hearing Request # 820188

NOTICE OF DECISION

PARTY

██████████
████████████████████
████████████████████

PROCEDURAL BACKGROUND

On ██████████ 2017, the Health Insurance Exchange Access Health CT (“AHCT”) sent ██████████, (the “Appellant”) a notice discontinuing HUSKY A Medicaid coverage for the Appellant and his two stepchildren ██████████ and ██████████ effective ██████████/17 for failure to provide 90 day verification.

On ██████████ 2017, The Appellant requested a hearing to contest the discontinuance of the HUSKY A Medicaid.

On ██████████ 2017, the Office of legal Counsel, Regulations, and Administrative Hearings (“OLCRAH”) issued a notice scheduling the administrative hearing for ██████████ 2017.

On ██████████ 2017, OLCRAH issued a notice rescheduling the administrative hearing for ██████████ 2017.

On ██████████ 2017, in accordance with sections 17b-60, 17b-264 and 4-176e to 4- 189, inclusive, of the Connecticut General Statutes, Title 45 Code of Federal Regulations (“CFR”) §§ 155.505(b) and 155.510 and/or 42 CFR § 457.113, OLCRAH held an administrative hearing by telephone.

The following individuals were present via telephone at the hearing:

██████████ Appellant
Cathy Davis, Access Health CT, Appeals Coordinator
Marci Ostroski, Hearing Officer

On ██████████ 2017 OLCRAH issued a notice to reconvene the administrative hearing for ██████████ 2017.

The following individuals were present via telephone at the reconvened hearing:

██████████ Appellant
Cathy Davis, Access Health CT, Appeals Coordinator
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 ██████████ 2017.

STATEMENT OF THE ISSUE

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

FINDINGS OF FACT

1. On ██████████ 2016 The Appellant's medical assistance eligibility was renewed through Access Health and the Appellant and his two stepchildren ██████████ and ██████████ were continued on HUSKY A Medicaid. (Department's testimony).
2. The Appellant's household consists of himself, his spouse, and three children. (Hearing Record, Ex. 1: Application ██████████)
3. The Appellant, his spouse, and children requested medical coverage (Hearing Record, Ex. 1: Application ██████████)
4. On application ██████████ the Appellant self-declared \$27,500.00 in annual income and eligibility for HUSKY A Medicaid was determined using the self-declared annual income. (Hearing Record).
5. On ██████████ 2016 AHCT sent the Appellant an Additional Verifications Required notice requesting proof of the Appellant's and his spouse's annual income by ██████████ 2017. (Ex. 4: Notice of Action, ██████████/16)

6. On [REDACTED] 2016, an override application was submitted on behalf of the Appellant's family. (Hearing Record, Ex. 8: Notice of Action [REDACTED]/16)
7. On [REDACTED] 2016 AHCT sent the Appellant an Additional Verifications Required notice requesting proof of the Appellant's and his spouse's annual income by [REDACTED] 2017. (Ex. 8: Notice of Action, [REDACTED]/16)
8. On [REDACTED] 2016, a change report application was submitted on behalf of the Appellant's family. (Ex. 12: Notice of Action [REDACTED]/16)
9. On [REDACTED] 2016 AHCT sent the Appellant an Additional Verifications Required notice requesting proof of the Appellant's and his spouse's annual income by [REDACTED] 2017. (Ex. 8: Notice of Action, [REDACTED]/16)
10. On [REDACTED] 2016, [REDACTED] 2016, [REDACTED] 2016, [REDACTED] 2017, [REDACTED] 2017, [REDACTED] 2017, [REDACTED] 2017, and [REDACTED] 2017, AHCT sent the Appellant Reminder-Additional Documents Needed notices requesting proof of the Appellant's and spouse's annual income by the latest due date of [REDACTED] 2017. (Ex. 5: Notice of Action, [REDACTED]/16, Ex. 6: Notice of Action, [REDACTED]/17, Ex. 7: Notice of Action, [REDACTED]/17, Ex. 9: Notice of Action, [REDACTED]/17, Ex. 10: Notice of Action, [REDACTED]/17, Ex. 11: Notice of Action, [REDACTED]/17, Ex. 13: Notice of Action, [REDACTED]/16, Ex. 14: Notice of Action, [REDACTED]/17, Ex. 15: Notice of Action, [REDACTED]/17).
11. On [REDACTED] 2017, AHCT received from the Appellant a 2015 Federal tax return and copies of paychecks. The pay checks did not show gross pay. AHCT's copy of the tax return was unreadable. (Ex. 16: Wage Verifications, Hearing Summary).
12. On [REDACTED] 2017, AHCT sent a Verification Failed letter to the Appellant failing the income verification sent. (Ex. 17: Notice of Action; Verification Failed, [REDACTED]/17)
13. On [REDACTED] 2017, AHCT discontinued the Appellant's HUSKY A Medicaid effective [REDACTED] 2017 for failure to provide income verification within 90 days. (Ex.1: Application [REDACTED] Ex. 2: Eligibility Results).
14. On [REDACTED] 2017, AHCT confirmed the Appellant's income based on verifications submitted by the Appellant to the appeals department of AHCT. (Ex. 19: Case Notes)
15. On [REDACTED] 2017 AHCT accepted the Appellant's verification of income and reinstated HUSKY A Medicaid for the Appellant and his two step children retroactively effective [REDACTED] 2017. There was no lapse in coverage. (Ex. 19: Case Notes, Ex. 22: Eligibility Results, Ex. 23: Enrollment Details, Ex. 26: STAT screen [REDACTED]/17)

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 § 155.310 (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.
11. 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
12. 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.


13. AHCT correctly issued notices to the Appellant that requested additional documents within 90 days to validate eligibility for healthcare coverage.
14. AHCT discontinued the Appellant's family's HUSKY A Medicaid when it determined that it did not have sufficient verification to validate eligibility for healthcare coverage.
15. AHCT reinstated the Appellant's family's HUSKY A Medicaid retroactive to its date of discontinuance once it determined that it did have sufficient documentation to verify the Appellant's income.
16. Uniform Policy Manual § 1570.25 (C) provides in part that the administrative duties of Fair Hearing Official is to determine the issue of the hearing, consider all relevant issues, and render a Fair Hearing decision in the name of the Department, in accordance with the criteria in this chapter, to resolve the dispute.
17. AHCT voided the action that led to the Appellant's request for an administrative hearing.
18. There is no action to be adjudicated.

DISCUSSION

AHCT has voided the action that led to the Appellant's request for this administrative hearing hereby resolving the issues to be adjudicated. The Appellant's Family's HUSKY A Medicaid was reinstated, effective [REDACTED] 2017 with no lapse in coverage. Consequently, the Appellant's appeal is hereby dismissed as the issue that led to the Appellant's request for this administrative hearing has been resolved.

DECISION

The Appellant's Appeal is **DISMISSED AS MOOT.**



Marci Ostroski
Hearing Officer

Pc: Cathy Davis, Judy Boucher, Health Insurance Exchange Access Health CT

**Modified Adjusted Gross Income (MAGI) Medicaid and
Children's Health Insurance Program (CHIP)
Right to Request Reconsideration**

For denials or reductions of MAGI Medicaid and CHIP, the Appellant has the right to file a written reconsideration request within 15 days of the mailing date of the decision on the grounds there was an error of fact or law, new evidence has been discovered or other good cause exists. If the request for reconsideration is granted, the Appellant will be notified within 25 days of the request date. No response within 25 days means that the request for reconsideration has been denied. The right to request a reconsideration is based on §4-181a(a) of the Connecticut General Statutes.

Reconsideration requests should include specific grounds for the request: for example, indicate what error of fact or law, what new evidence, or what other good cause exists. Reconsideration requests should be sent to: Department of Social Services, Director, Office of Legal Counsel, Regulations, and Administrative Hearings, 55 Farmington Avenue, Hartford, CT 06105-3725.

Right to Appeal

For denials, terminations or reductions of MAGI Medicaid and CHIP eligibility, the Appellant has the right to appeal this decision to Superior Court within 45 days of the mailing of this decision, or 45 days after the agency denies a petition for reconsideration of this decision, provided that the petition for reconsideration was filed timely with the Department. The right to appeal is based on §4-183 of the Connecticut General Statutes. To appeal, a petition must be filed at Superior Court. A copy of the petition must be served upon the Office of the Attorney General, 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 extensions 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.