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

[redacted] 2018
Signature confirmation

Case: [redacted]
Client: [redacted]
Application: [redacted]
Request: [redacted]

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted], 2017, [redacted] (the "Appellant") filed a request for an administrative hearing with the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") stating that she could not afford private medical insurance through her employer.

On [redacted], 2017, the OLCRAH issued a notice scheduling the administrative hearing for [redacted] 2018, with a copy to Access Health Connecticut ("AHCT"), Connecticut's Health Insurance Exchange.

On [redacted] 2018, 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 ("C.F.R.") §§ 155.505(b) and 155.510 and/or 42 C.F.R. § 457.113, OLCRAH held an administrative hearing by telephone. The following individuals participated in the administrative hearing:

[redacted], Appellant
Krystal Sherman-Davis, AHCT's representative
Eva Tar, Hearing Officer

The administrative hearing record closed [redacted] 2018.

STATEMENT OF ISSUE

The issue to be decided by this proceeding is whether AHCT took an action to reduce or deny the Appellant's HUSKY A/Medicaid for Parents & Caretakers coverage.

FINDINGS OF FACT

1. On [redacted] 2017, AHCT issued a notice renewing the Appellant's HUSKY A/Medicaid for Parents & Caretaker's coverage for the period from [redacted] 2017 through [redacted] 2018. (AHCT's Exhibit B)

2. In [redacted] 2017, the Appellant had HUSKY A/Medicaid for Parents & Caretakers coverage. (AHCT's representative's testimony)(AHCT's Exhibit B)(AHCT's Exhibit C)

3. On [redacted] 2017, the Appellant filed a request for an administrative hearing. (Hearing record)

4. The Appellant filed her hearing request because she found AHCT's numerous notices confusing. (Appellant's testimony)

CONCLUSIONS OF LAW

1. 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. Conn. Gen. Stat. § 17b-260.

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

3. 45 C.F.R. § 155.110 (a) 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: (1) An entity: (i) Incorporated under, and subject to the laws of, one or more States; (ii) That has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and(iii) Is not a health insurance issuer or treated as a health insurance issuer under subsection (a) or (b) of section 52 of the Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or (2) The State Medicaid agency, or any other State agency that meets the qualifications of paragraph (a)(1) of this section.

4. **Basis and scope**. This subpart—(a) Implements section 1902(a)(3) of the Act, which requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly; (b) Prescribes procedures for an opportunity for a hearing if the State agency or non-emergency transportation PAHP (as defined in §438.9(a) of this chapter) takes action, as stated in this subpart, to

suspend, terminate, or reduce services, or of an adverse benefit determination by an MCO, PIHP or PAHP under subpart F of part 438 of this chapter; and (c) Implements sections 1919(f)(3) and 1919(e)(7)(F) of the Act by providing an appeals process for any person who—(1) Is subject to a proposed transfer or discharge from a nursing facility; or (2) Is adversely affected by the pre-admission screening or the annual resident review that are required by section 1919(e)(7) of the Act. (d) Implements section 1943(b)(3) of the Act and section 1413 of the Affordable Care Act to permit coordinated hearings and appeals among insurance affordability programs. 42 C.F.R. § 431.200.

For the purposes of this subpart: *Action* means a termination, suspension of, or reduction in covered benefits or services, or a termination, suspension of, or reduction in Medicaid eligibility or an increase in beneficiary liability, including a determination that a beneficiary must incur a greater amount of medical expenses in order to establish income eligibility in accordance with §435.121(e)(4) or §435.831 of this chapter or is subject to an increase in premiums or cost-sharing charges under subpart A of part 447 of this chapter. It also means a determination by a skilled nursing facility or nursing facility to transfer or discharge a resident and an adverse determination by a State with regard to the preadmission screening and resident review requirements of section 1919(e)(7) of the Act. 42 C.F.R. § 431.201.

5. The State agency must grant an opportunity for a hearing to the following: (1) Any individual who requests it because he or she believes the agency has taken an action erroneously, denied his or her claim for eligibility or for covered benefits or services, or issued a determination of an individual's liability, or has not acted upon the claim with reasonable promptness including, if applicable—(i) An initial or subsequent decision regarding eligibility; (ii) A determination of the amount of medical expenses that an individual must incur in order to establish eligibility in accordance with §435.121(e)(4) or §435.831 of this chapter; or (iii) A determination of the amount of premiums and cost sharing charges under subpart A of part 447 of this chapter; (iv) A change in the amount or type of benefits or services; or (v) A request for exemption from mandatory enrollment in an Alternative Benefit Plan. 42 C.F.R. § 431.220 (a)(1).

   Section 17b-60 of the Connecticut General Statutes provides in part that an aggrieved person authorized by law to request a fair hearing on a decision of the Commissioner of Social Services or the conservator of any such person on his behalf may make application for such hearing in writing over his signature to the commissioner and shall state in such application in simple language the reasons why he claims to be aggrieved. Such application shall be mailed to the commissioner within sixty days after the rendition of such decision. The commissioner shall thereupon hold a fair hearing within thirty days from receipt thereof and shall, at least ten days prior to the date of such hearing, mail a notice, giving the time and place thereof, to such aggrieved person, or if the application concerns a denial of or failure to provide emergency housing, the commissioner shall hold a fair hearing within four business days from receipt thereof, and shall make all reasonable efforts to provide notice of the time and place of the fair hearing to such aggrieved person at least one business day prior to said hearing.

   The purpose of the Fair Hearing process is to allow the requester of the Fair Hearing to present his or her case to an impartial hearing officer if the requested claims that the

Department has either acted erroneously or has failed to take a necessary action with a reasonable period of time. Uniform Policy Manual ("UPM") § 1570.05 (A).

Subject to the conditions described in this chapter, the requester has the right to a Fair Hearing if: 1. the Department denies the assistance unit's application for benefits; or 2. the Department does not take action on the assistance unit's application within the time limits specified in Section 1500; or 3. the requester feels that the Department has either failed to take a required action or has taken an erroneous action. Such actions include: suspending, reducing, discontinuing, or terminating benefits; or b. imposing conditions upon eligibility; or c. issuing benefits in a manner other than directly to the assistance unit; or d. taking any other action affecting the receipt of benefits, such as computing the amount of benefits. UPM § 1570.05 (B).

6. As of [redacted], 2017, AHCT had neither denied the Appellant her HUSKY A/Medicaid for Parents & Caretakers coverage nor reduced her household's covered benefits or services.

7. As of [redacted] 2017, the Appellant was not an aggrieved individual, as contemplated by Conn. Gen. Stat. § 17b-60.

8. At the time of her [redacted] 2017 hearing request, the Appellant did not have a right to a fair hearing.

DISCUSSION

As of [redacted], 2017, the date of the Appellant's request for an administrative hearing, AHCT had taken no adverse action regarding the Appellant's HUSKY A/Medicaid for Parents & Caretakers coverage.

DECISION

The issue of this administrative hearing is moot, as the Appellant's request for an administrative hearing was granted in error.

Eva Tar-electronic signature
Eva Tar
Hearing Officer

Cc: Krystal Sherman-Davis, AHCT
Amanda Maloney, AHCT

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

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

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

Right to Appeal

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