STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT 06105-3725

[redacted] **2018**
Signature Confirmation

Client ID # [redacted]
Hearing Request # 121443

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2018, the Health Insurance Exchange, Access Health CT ("AHCT") issued a notice to [redacted], (the "Appellant"), discontinuing her Medicaid/HUSKY D healthcare coverage.

On [redacted] 2018, the Appellant requested an administrative hearing to contest the discontinuance of Medicaid/HUSKY D healthcare coverage.

On [redacted], 2018, the Office of legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2018.

On [redacted] 2018, the Appellant requested her administrative hearing be rescheduled.

On [redacted] 2018, the OLCRAH issued a notice scheduling the administrative hearing for [redacted] 2018.

On [redacted], 2018, the Appellant requested her administrative hearing be rescheduled.

On [redacted] 2018, OLCRAH issued a notice scheduling the administrative hearing for [redacted] 2018.

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 of the 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 participated in the hearing:

[redacted], Appellant
Cathy Davis, AHCT Representative
Scott Zuckerman, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT correctly discontinued the Appellant's Medicaid/HUSKY D healthcare coverage.

FINDINGS OF FACT

1. The Appellant received Husky D Medicaid. (Hearing record)

2. On [redacted], 2018, AHCT reviewed the Appellant's eligibility for Husky D Medicaid. (Hearing record)

3. On the Appellant's application she listed monthly household earnings of $1,220.68. (Exhibit 8: Application form)

4. The self-declared income reported on the application by the Appellant did not match federal income verification sources accessed by AHCT. (Hearing Summary, AHCT testimony)

5. On [redacted] 2018, AHCT sent the Appellant an Additional Verification Required notice requesting that the Appellant provide verification of the household's earned income no later than [redacted] 2018. The notice further advised the Appellant that Medicaid eligibility would end [redacted] 2018, if she did not provide the documents. (Ex. 2: Verification request, [redacted]18)

6. On [redacted] 2018, AHCT sent the Appellant a reminder notice requesting that the Appellant provide verification of the household's earned income no later than [redacted] 2018. The notice further advised the Appellant that Medicaid eligibility would end [redacted] 2018 if she did not provide the documents. (Ex. 3: Reminder request, [redacted]/18)

7. On [redacted] 2018, AHCT sent the Appellant a reminder notice requesting that the Appellant provide verification of the household's earned income no later than [redacted], 2018. The notice further advised the Appellant that Medicaid eligibility would end [redacted] 2018 if she did not provide the documents. (Ex. 4: Reminder request, [redacted]18)

8. On [redacted] 2018, AHCT sent the Appellant a reminder notice requesting that the Appellant provide verification of the household's earned income. The notice further advised the Appellant that Medicaid eligibility would end [redacted] 2018 if she did not provide the documents. (Ex. 5: Reminder request, [redacted]18)

8. The Appellant did not submit the required verifications of the household's income to AHCT. (Appellant's testimony, AHCT testimony)

10. On [redacted] 2018, AHCT issued a notice to the Appellant informing her that effective [redacted], 2018, she no longer qualified for Husky D health coverage because she did not prove the household's monthly income. (Ex. 6: Loss of Health Coverage notice, [redacted]/18)

CONCLUSIONS OF LAW

1. Section 17b-260 of the Connecticut General Statute provides that 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. State statute provides that 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. Stats. § 17b-264]

3. 45 CFR § 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. 45 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) or this section that is designated by the Exchange, if the Exchange establishes an appeals process in accordance with the requirements of this subpart.

5. 45 CFR § 155.505(d) provides that an appeals process established under this subpart must comply with § 155.110(a).

6. 45 CFR § 155.300(b) Medicaid and CHIP In general, references to Medicaid and CHIP regulations in this subpart refer to those regulations as implemented in accordance with rules and procedures which are the same as those applied by the State Medicaid or State CHIP agency or approved by such agency in the agreement described in § 155.345(a).

7. 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.

8. The Appellant's eligibility for Medicaid must be determined by the Exchange AHCT because the Appellant is part of the population of individuals described in 45 CFR 155.305(c)(4).

9. 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.

10. 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.

11. AHCT was required to verify the Appellant's current income because the self-declared income reported by the Appellant was not reasonably compatible with income information obtained through an electronic data match. The Appellant's self-declared income, which was below the income threshold, was different from what was reflected in electronic data match information.

12. 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 her 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.

13. AHCT provided the Appellant with a notice informing her that information necessary to complete her eligibility determination was missing, and specified in the notice what information was missing, and provided instructions on how to provide the missing information, and provided the Appellant with no less than 10 days and no more than 90 days from the date of the initial request to provide the information.

14. AHCT was correct when it discontinued the Appellant's HUSKY D, because the Appellant, after being properly notified, failed to provide AHCT, by the due date, with the information necessary to complete her eligibility determination.

DECISION

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

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Scott Zuckerman
Hearing Officer

C: Becky Brown, Health Insurance Exchange, Access Health CT
Mike Towers, Health Insurance, Exchange, Access Health CT
Cathy Davis, 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 her 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.