**STATE OF CONNECTICUT**
**DEPARTMENT OF SOCIAL SERVICES**
**OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS**
**55 FARMINGTON AVENUE**
**HARTFORD, CT 06105-9902**

[redacted] **2023**
**Signature Confirmation**

**Case #** [redacted]
**Client #** [redacted]
**Request # 221555**

## NOTICE OF DECISION
## PARTY

[redacted]

## PROCEDURAL BACKGROUND

On [redacted] 2023, the Department of Social Services - ("the Department") sent [redacted] (the "Appellant") a Notice of Action ("NOA") which discontinued Husky D Medicaid effective [redacted], 2023, because the redetermination process was not completed.

On [redacted] 2023, the Appellant, requested an administrative hearing to contest the Department's determination.

On [redacted], 2023, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted], 2023.

On [redacted], 2023, in accordance with sections 17b-60, 17-61 and 4-176e to 4-189 inclusive of the Connecticut General Statutes, OLCRAH held an administrative hearing.

The following individuals were present at the hearing:

[redacted], Appellant
Vanessa Harrison, Department's Representative
Almelinda McLeod, Hearing Officer

## STATEMENT OF THE ISSUE

The issue to be decided is whether the Department correctly discontinued the Appellant's renewal application for Husky D Medicaid effective [redacted], 2023, in accordance with regulations.

## FINDINGS OF FACT

1. The Appellant is a household of one who was active Husky D, Adult Medicaid coverage from [redacted] 2020, to [redacted], 2023. (Hearing record)

2. On [redacted] 2023, AHCT issued a Husky Annual Renewal notice to the Appellant. The Renewal notice indicated AHCT was unable to automatically renew Husky D without some updated information. The notice listed options to renew as: online at www.accesshealthct.com; by calling Access Health CT at 1-855-805-4325; by mail by sending the pre-filled renewal form included with this notice or in person. The due date to update her information and renew her Husky health coverage was [redacted]t [redacted] 2023. Failure to contact AHCT by the due date, would result in the Appellant losing her Husky Health coverage effective [redacted], 2023. (Exhibit 1, Notice # 1305)

3. On [redacted] 2023, AHCT issued a Renewal Reminder notice to the Appellant requesting the Appellant contact AHCT to complete her renewal. The notice indicated that if coverage was not renewed by [redacted], 2023, the coverage would end [redacted], 2023. (Exhibit 2, Notice #1334)

4. On [redacted] 2023, AHCT did not receive the renewal or any contact from the Appellant. (AHCT testimony)

5. On [redacted], 2023, AHCT submitted a change reporting application and determined the Appellant was not eligible for the Husky D health coverage. (Exhibit 3, application # [redacted] Hearing record)

6. On [redacted] 2023, AHCT issued a notice informing the Appellant the Husky D coverage was ending effective [redacted], 2023, for failing to renew her medical coverage. (Exhibit 5, Renewal decision Notice # 1337)

7. On [redacted], 2023, AHCT received the Appellant's unsigned renewal form with 4 paystubs. The renewal was returned for a signature. (Hearing record)

8. On [redacted] 2023, the Appellant's Husky D health coverage was closed. (Hearing record)

9. On [redacted] 2023, AHCT received the signed copy of the renewal, however, the 4 paystubs presented could not be verified because data sources showed a higher income than what was reported. AHCT attempted to verify the income, but the Appellant was not comfortable providing a social security number over the phone and would rather verify the income in the mail. (Hearing record)

10. As of the date of this hearing, [redacted] 2023, AHCT has not received the requested income verification needed to determine eligibility. The Husky D coverage remained closed. (Hearing record)

The issuance of this decision is timely under section 17b-61(a) of Connecticut General Statutes, which requires that a decision be issued within 90 days of the request for an administrative hearing. The Appellant requested an administrative hearing on [redacted] 2023. This decision, therefore, was due no later than [redacted], 2023.

## CONCLUSIONS OF LAW

1. Section §17b-260 of the Connecticut General Statutes ("Conn. Gen. Stat.") 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 Conn. Gen. Stat. 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 Code of Federal Regulations ("CFR") §155.110 (A) (2) provides the State may elect to authorize an Exchange established by the State to enter into an agreement with an eligible entity to carry out or more responsibilities of the Exchange. An eligible entity is the State Medicaid agency, or any other State agency that meets the qualifications of paragraph (a) (1) of this section.

4. Title 45 CFR §155.505 (c)(1) provides Options for Exchange appeals. 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 appeals process in accordance with the requirements of this subpart; or

5. Title 45 CFR §155.505 (d) Eligible entities. An appeals process established under this subpart must comply with § 155.110 (a).

6. Title 42 CFR §435.119 (a) Basis**.** This section implements section 1902(a)(10)(A)(i)(VIII) of the Act. (b) Eligibility**.** Effective January 1, 2014, the agency must provide Medicaid to individuals who: (1) Are age 19 or older and under age 65; (2) Are not pregnant; (3) Are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act; (4) Are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part; and (5) Have household income that is at or below 133 percent FPL for the applicable family size.

7. Title 45 CFR §155.335 (a) pertains to the annual eligibility redetermination and provides, in part, the Exchange must redetermine the eligibility of a qualified individual on an annual basis.

*8.* Title 42 CFR §435.916 (a) (1) pertaining to Renewal of individuals whose Medicaid eligibility is based on modified adjusted gross income methods (MAGI) provides, in part, the eligibility of Medicaid beneficiaries whose financial eligibility is determined using MAGI-based income must be renewed once every 12 months, and no more frequently than once every 12 months.

*9.* Title 42 CFR §435.916 (a) (3)(i) (A) provides that the use of a pre-populated renewal form as a method of renewal for individuals whose Medicaid is based on modified adjusted gross income. If the agency cannot renew eligibility in accordance with paragraph (a) (2) of this section, the agency must provide the individual with a renewal form containing information, as specified by the Secretary, available to the agency that is needed to renew eligibility.

10. "The department's Uniform Policy Manual ("UPM") is the equivalent of state regulation and, as such, carries the force of law." Bucchere v. Rowe, 43 Conn. Supp. 175, 178 (1994) (citing Conn. Gen. Stat. § 17b-10; Richard v. Commissioner of Income Maintenance, 214 Conn. 601, 573 A.2d 712 (1990)).

11. Uniform Policy Manual ("UPM") §1010.05 (A) (1) provides that the assistance unit must supply the Department in an accurate and timely manner as defined by the Department, all pertinent information, and verification that the Department requires to determine eligibility and calculate the amount of benefits.

***12.*** **AHCT correctly issued the Renewal Notice to the Appellant on [redacted] 2023, in compliance with regulations.**

*13.* Title 42 CFR §435.916 (a) (2) provides, in part, Renewal on basis of information available to agency. The agency must make a redetermination of eligibility without requiring information from the individual *if able to do so* based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency under §§ 435.948, 435.949 and 435.956 of this part.

**14. AHCT correctly attempted to renew the Appellant's Husky health coverage without asking for more information, however; updated information was needed to renew the Appellant's coverage, thus AHCT correctly determined the Appellant's eligibility could not be automatically renewed.**

*15.* Title 42 CFR §435.916 (a) (3) (i) (B) provides that at least 30 days from the date of the renewal form to respond and provide any necessary information through any of the modes of submission specified in §435.907 (a) of this part, and to sign the renewal form in a manner consistent with §435.907 (f) of this part.

*16.* **AHCT correctly issued the Reminder Notice to the Appellant on [redacted], 2023, which was within the 30 days [redacted] 2023) the renewal was mailed to the Appellant. The reminder notice informed the Appellant the health coverage was not renewed, and the Appellant had until [redacted], 2023, to complete the renewal or coverage will end on [redacted], 2023.**

*17.* Title 42 CFR §435.907 (f) provides the agency must require that all initial applications are signed under penalty of perjury. Electronic, including telephonically recorded, signatures and handwritten signatures transmitted via any other electronic transmission must be accepted.

**18.** Title 45 CFR §155.335 (g) (2) provides -To the extent that a qualified individual does not sign and return the notice described in paragraph (c) of this section within the 30-day period specified in paragraph (e) of this section, the Exchange must proceed in accordance with the procedures specified in paragraph (h)(1) of this section.

**19.** Title 45 CFR §155.335 (h) (1) Redetermine the qualified individual's eligibility in accordance with the standards specified in § 155.305 using the information provided to the qualified individual in the notice specified in paragraph (c) of this section, as supplemented with any information reported by the qualified individual and verified by the Exchange in accordance with paragraphs (e) and (f) of this section.

20. **AHCT correctly determined that a signed renewal application was not received by the deadline, [redacted] 2023. Therefore, AHCT correctly concluded they were unable to determine the Appellant's eligibility for ongoing coverage.**

**21.** Title 42 CFR §435.917 (b) (2) pertains to notice of agency's decision concerning eligibility, benefits, or services and provides notice of adverse action including denial, termination or suspension of eligibility or change in benefits or services. Any notice of denial, termination or suspension of Medicaid eligibility or change in benefits or services must be consistent with § 431.210 of this chapter.

**22.** Title 42 CFR §435.916 (a) (3) (iii) provides notice of the agency's decision concerning the renewal of eligibility in accordance with his subpart and ….reconsider in a timely manner the eligibility of a individual who is terminated for failure to submit the renewal form or necessary information, if the individual subsequently submits the renewal form within 90 days after the date of termination, or a longer period elected by the State, without requiring a new application.

**23. AHCT correctly determined the Appellant was not eligible for Husky D because of failure to renew.**

**24. AHCT correctly provided the Appellant proper notice regarding the discontinuation of the Husky D effective [redacted], 2023, due to failure to renew.**

25. **AHCT received the subsequent *signed* renewal on [redacted] 2023, which is within the 90 days after the date of termination, therefore, AHCT correctly determined no new application was required and are correctly in the process of reconsidering the Appellant's eligibility for Husky D Medicaid coverage.**

## DECISION

The Appellant's appeal is Denied.

*Almelinda McLeod*
Almelinda McLeod
Hearing Officer

CC: Becky.Brown@conduent.com
Mike.Towers@conduent.com
Vanessa.Harrison@conduent.com

## 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, 165 Capitol Avenue, 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 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.