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

[redacted] **23, 2023**
Signature Confirmation

Case # [redacted]
Client # [redacted]
Request # 215909

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2023, [redacted] ("the Appellant"), requested an administrative hearing to contest the Health Insurance Exchange Access CT ("AHCT") processing of the Appellant's application for Medicaid Husky D Low Income Adult healthcare coverage.

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, the Appellant requested a reschedule and it was granted.
On [redacted], 2023, OLCRAH issued a notice scheduling the administrative hearing for [redacted], 2023.

On [redacted] 2023, the Appellant requested a reschedule and it was granted.
On [redacted], 2023, OLCRAH issued a notice of administrative hearing for [redacted], 2023.

On [redacted], 2023, the Appellant requested a reschedule and it was granted.
On [redacted], 2023, OLCRAH issued a final reschedule of 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
Cathy Davis, AHCT Grievance Coordinator, Department's Representative
Almelinda McLeod, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department correctly delayed processing the Appellant's application for Husky D Medicaid benefits.

FINDINGS OF FACT

1. On [redacted] 2023, [redacted]) applied for Husky D assistance on behalf of the Appellant specifically interested in obtaining medical benefits for the month of [redacted] 2023. (Exhibit B 1-4 & Exhibit 3)

2. The household consisted of the Appellant. He is a household of one. (Hearing record)

3. On [redacted] 2023, the Department did not process the Appellant's application. Instead, the Department put the application on hold for more information. (Hearing record)

4. The information the Department sought was the Appellant's [redacted] wages. (Department testimony)

5. The Appellant submitted e-mail verification of his [redacted] wages dated on [redacted] 2023, to [redacted] for the submission of his application. See below chart: (Exhibit C)

[redacted] 2023	$110.00
[redacted] 2023	$440.00
[redacted] 2023	$370.00
[redacted], 2023	$60.00
[redacted] 2023	$555.00
Total wages in [redacted] 2023	$1535.00/ 5 x 4.3 = $1320.10

6. The Appellant did not receive any correspondence or communication requesting more information after he submitted his [redacted] wages to [redacted] representative. (Appellant testimony)

7. As of the date of this hearing, the department had not received the Appellant's [redacted] 2023 wages from [redacted]. (Department testimony)

8. As of the Date of this hearing, [redacted] 2023, the Appellants Husky D application remains in a process delay status. (Hearing record)

The issuance of this decision is timely under Connecticut General Statutes §17b-61(a), 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 is not due until [redacted] 2023. However, the Appellant's attorney requested to reschedule the administrative hearing on three occasions. In addition, the hearing record was re-opened for additional information causing a total of a 38-day delay. Therefore, the final decision is not due until [redacted] 2023, and is therefore timely.

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 of the Code of Federal Regulations ("C.F.R.") § 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. Title 45 C.F.R. § 155.505(d) provides that an appeals process established under this subpart must comply with § 155.110(a).

5. Title 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.

6. Title 42 CFR § 435.952 (a) provides 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.

7. Title 42 CFR § 435.952 (c) (2) (i) provides, in part, 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.

8. UPM § 1015.10 (A) provides that the Department must inform the assistance unit regarding the eligibility requirements of the programs administered by the Department, and regarding the unit's rights and responsibilities.

9. Title 42 CFR § 435.912 (e) provides the agency must determine eligibility within the standards except in unusual circumstances, for example— (1) When the agency cannot reach a decision because the applicant or an examining physician delay or fails to take a required action, or (2) When there is an administrative or other emergency beyond the agency's control.

10. Title 42 CFR § 435.912 (a) For purposes of this section— (1) "Timeliness standards" refer to the maximum period of time in which every applicant is entitled to a determination of eligibility, subject to the exceptions in paragraph (e) of this section. (2) "Performance standards" are overall standards for determining eligibility in an efficient and timely manner

across a pool of applicants, and include standards for accuracy and consumer satisfaction, but do not include standards for an individual applicant's determination of eligibility.

11. Title 42 CFR § 435.912 (b) Consistent with guidance issued by the Secretary, the agency must establish in its State Plan timeliness and performance standards for, promptly and without undue delay— (1) Determining eligibility for Medicaid for individuals who submit applications to the single State agency or its designee. (2) Determining potential eligibility for, and transferring individuals' electronic accounts to, other insurance affordability programs pursuant to § 435.1200(e) of this part. (3) Determining eligibility for Medicaid for individuals whose accounts are transferred from other insurance affordability programs, including at initial application as well as at a regularly scheduled renewal or due to a change in circumstances.

12. Title 42 CFR § 435.912 (c) (3) provides Except as provided in paragraph (e) of this section, the determination of eligibility for any applicant may not exceed— (i) Ninety days for applicants who apply for Medicaid on the basis of disability; and (ii) Forty-five days for all other applicants.

13. 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.

AHCT incorrectly failed to process the application when they received it and instead held onto the application on [redacted], 2023.

The hearing record shows AHCT failed to send out a notice requesting more information and failed to inform the Appellant or [redacted] what was needed to determine eligibility for Husky D assistance.

The hearing record shows AHCT failed to send notification to the Appellant regarding the status of the Appellant's application.

The hearing record shows AHCT failed to determine eligibility within the forty-five days in accordance with 42 CFR 435.435.912 (c) (3).

DISCUSSION

AHCT acknowledged that upon receipt of the Appellant's application, the application was not processed, instead, it was held onto for wage information. The Appellant verified he supplied his [redacted]2023 income information to [redacted] for the submission of his application. There is no record that AHCT sent notice requesting income verification to the Appellant or his representatives at [redacted]. The hearing record shows AHCT did not meet the standard of promptness and has not processed the case timely.

DECISION

The Appellant's appeal is granted.

ORDER

1. AHCT is ordered to review all information submitted for the Husky D application submitted on behalf of the Appellant by [redacted], including, the wages supplied for this hearing and process for the retro medical, benefits for the month of [redacted] 2023.

2. AHCT shall make a determination of eligibility and provide a notice.

3. Compliance with this order shall be submitted to the undersigned no later than [redacted] 2023.

Almelinda McLeod
Almelinda McLeod
Hearing Officer

CC: Becky.Brown@Conduent.com
Mike.Towers@Conduent,com
Cathy.Davis@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.