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VIA ELECTRONIC DELIVERY

June 30, 2015

Commissioner Roderick Bremby
Department of Social Services
55 Farmington Avenue
Hartford, CT 06106

Re: Implementation of the Change in Income Eligibility for Parents Under the HUSKY A Program

Dear Commissioner Bremby:

As you are aware, the General Assembly has passed legislation reducing the income eligibility of the HUSKY A program for parents from 201% to 155% of the federal poverty level, effective August 1st. The budget suggests that the vast majority of the affected families have earned income and, thus, will qualify for one year of transitional medical assistance (TMA).

But among those who will not qualify for TMA, there may be other coverage groups under which they can continue to qualify for full or limited benefit Medicaid coverage. At a presentation to the Covering Kids group on June 17, 2015, DSS officials indicated that, for the 1350 affected individuals who do not have earned income, they planned only to inform them to apply for subsidized health insurance through a qualified health plan, and not to check, and maintain uninterrupted coverage, for those eligible under other Medicaid categories. Rather, they indicated that those who qualify for continued eligibility under another Medicaid eligibility group will have to affirmatively **reapply** for such coverage. Such inaction would violate state and federal law.

The Department must conduct an individualized review of each of the approximately 23,750 individuals impacted by the lowered eligibility standards to ascertain whether it has information demonstrating that the person is eligible for Medicaid under another coverage category. This must include a review of any pending un-reviewed documents in any ConneCT or AHCT queues. People whose income has changed also need an opportunity to bring this to the attention of the Department before discontinuance. Those who have earned income and thus qualify for TMA must be issued a notice explaining the basis for the HUSKY A discontinuance, the amount of income that is the basis of this determination, and a description of the TMA program.

For those who will **not** qualify for TMA, the Department must review each case to determine whether there is another Medicaid full or limited benefit coverage group under which they might qualify as required by federal law¹ and the newly passed legislative mandate, CT General Statutes §17b-276, as amended by Section 374 of SB 1502. The new legislation mandates an individualized review of each case:



¹ 42 U.S.C. § 1396a(a)(8) and 42 C.F.R. § 435.930.

Sec. 374. (NEW) (*Effective from passage*) (a) The Commissioner of Social Services shall review whether a parent or needy caretaker relative, who qualifies for Medicaid coverage under Section 1931 of the Social Security Act and is no longer eligible on and after August 1, 13694 2015, pursuant to section 17b-261 of the general statutes, as amended by this act, remains eligible for Medicaid under the same or a different category of coverage before terminating coverage.

The Department faced a similar challenge in 2003, the subject of the *Rabin v. Wilson-Coker* litigation. 266 F. Supp. 2d 332 (D. Conn. 2003), *affirmed in part, reversed in part*, 362 F.3d 190 (2d Cir. 2004). The decision in that case provides some useful guidance for identifying potential alternative coverage groups: pregnancy, MAABD, breast and cervical cancer and, since the *Rabin* case, the family planning group. There are other groups as well, including those eligible for the limited benefit for individuals with tuberculosis.

As it did in 2003, the Department must review DSS and CHNCT case files and claims data, and check with providers, to identify cases where someone is pregnant. The Department should also identify cases in which someone receives disability benefits (or is otherwise disabled) or is over age 65, and might qualify for the MAABD program with a spend-down because of high medical bills. The Department should also identify cases where someone was determined to have breast or cervical cancer through a CDC site, or where claims data or other sources show the individual has received diagnosis or treatment for TB. And, in light of the individualized review mandated by Section 374, it should also send individualized notices to individuals for whom there is some indication the person *might* so qualify but it cannot tell for sure from its internal records and records of other agencies,² and should not terminate anyone who timely responds in any way indicating they might be eligible until a full review has been completed. Finally, all those of childbearing age, not eligible under any other group, should be enrolled in the limited benefit family planning group.

As you know, under federal Medicaid regulations, individuals who are not eligible for TMA or for any other Medicaid benefit category must still receive written notice before their current HUSKY A coverage is terminated, with information about the right to appeal the decision and keep full benefits pending the hearing if a hearing is requested before the intended termination date.³ These regulations implement the constitutional due process requirements under the Fourteenth Amendment.⁴ Because the reduction in income limits only impacts parents and caretakers, it will be critically important for the notice to reassure recipients that their children continue to be eligible for HUSKY A. In all cases, benefits must continue if someone requests a hearing before the effective date of the discontinuance.

The notice approved by the lower court in *Rabin* -- not challenged on appeal -- stated that HUSKY A benefits had been terminated due to a change in the income limits, and described the alternative coverage categories for which the person had been considered prior to being issued the termination notice. Those categories would now include TMA. The notice informed the recipient that “[DSS] has *no* information that the adults in your house are eligible for Medicaid for one of these reasons. . .” The notices stated the income limits for the various coverage categories as well as information about the recipient’s income, and invited the recipient to call if the recipient believed s/he may still be eligible for Medicaid, stating: “If you think we have made a mistake [in calculating your income], call your worker right away. You

² In *Rabin*, the individualized process followed by DSS along these lines was described:

The Department has searched its files and contacted managed care organizations for information indicating that a HUSKY A adult might be eligible for coverage based on pregnancy. As a result of this process, at least 141 women have been reassigned to that eligibility category. The Department has also searched its files to identify HUSKY A recipients over age 65, who might qualify for continued coverage based on age, medical expenses, blindness or disability, and has contacted them in writing to determine if they qualify. At least 160 adults have been reassigned to another coverage group as a result.

Id. at n. 5.

³ 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.210 and 431.230.

⁴ *Goldberg v. Kelly*, 397 U.S. 254 (1970), *see* 42 C.F.R. § 431.205(d).

should also call your worker, if you have income under the limits, or you are pregnant, disabled, have high medical expenses, child care expenses, or you have breast or cervical cancer.” The Court also noted that it was its “understanding that *if an individual calls a caseworker in response to the new notice, she will continue to be insured until the Department reviews her file to determine whether she qualifies for coverage under a different eligibility category.*” Id. at n. 7 (emphasis added).

We recognize that, because the Department’s severely under-resourced systems require individuals calling the Department’s call centers to routinely wait long periods to reach a live person, many give up. In addition, individuals who timely send in documents through the scan centers for both AHCT and DSS have their documents unread and unprocessed in the AHCT and ConneCT respective queues for weeks or even months. This means that a person who in fact is eligible under another Medicaid benefit category, realizes this after getting a notice and timely responds to advise the Department accordingly by phone or mail, will be at risk of improper termination, absent essential fail-safes.

Accordingly, we urge the Department to implement the attached suggested framework to comply with the new state legislative mandate and the federal Medicaid requirements. This framework will:

- Ensure that each HUSKY A parent or caretaker relative is individually screened to determine whether s/he is still eligible for HUSKY A or eligible under another coverage group, including:
 - TMA
 - MAABD
 - Pregnant
 - Breast or Cervical Cancer
 - Tuberculosis
 - Family Planning group
- Ensure that proper notice is sent to all HUSKY A enrollees explaining DSS’ eligibility determination, the basis, and the enrollee’s due process rights.

Additional protections also are needed to ensure that individuals who are still eligible for HUSKY A or another full or limited benefit coverage group are not erroneously terminated when they have tried to contact DSS or AHCT to arrange such continued coverage. We urge the Department to:

- Have a dedicated telephone line at either DSS or AHCT with a separate queue for all HUSKY A terminations related to the change in the income guidelines, with that number prominently provided on all HUSKY A income guideline change or termination notices, with sufficient staff so that average waits are far below the current average wait times of the ConneCT call center.
- Since neither the Department nor AHCT is able to reliably identify the kinds of documents pending in its document queues, ensure that no one who is in this category is terminated until any documents related to that person pending in any such queues are actually reviewed and processed.

Conclusion

Given all the challenges DSS already faces, this will no doubt be a daunting undertaking. We are understandably concerned that the process could be confusing and disruptive for clients and believe the onus is on DSS to ensure that the transition to TMA or other Medicaid eligibility groups is as seamless as possible, that individuals who remain eligible for full benefit Medicaid coverage are not erroneously terminated from it, and that individuals eligible only for a limited benefit Medicaid group be placed in that group as well as advised of their eligibility for subsidized insurance on the

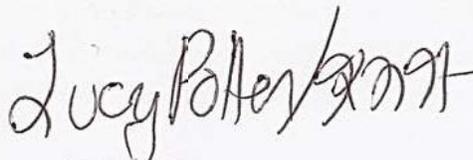
exchange.⁵ Following the attached framework should make this possible, while ensuring compliance with state and federal law.

Thank you very much for carefully considering these important recommendations.

Respectfully yours,



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Rep. Catherine Abercrombie
Sen. Marilyn Moore
Sen. Terry Gerratana
Rep. Susan Johnson
Sen. Beth Bye
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⁵ An individual can be eligible for both limited benefit Medicaid coverage and subsidized insurance on the exchange because limited benefit Medicaid is not "minimum essential coverage" disqualifying them from such subsidies.

Suggested framework for complying with the required review
for continuing or alternative Medicaid eligibility

Section 374 of SB 1502, passed by the legislature, provides: “(a) The Commissioner of Social Services shall review whether a parent or needy caretaker relative, who qualifies for Medicaid coverage under Section 1931 of the Social Security Act and is no longer eligible on and after August 1, 1, 2015, pursuant to section 17b-261 of the general statutes, as amended by this act, remains eligible for Medicaid under the same or a different category of coverage before terminating coverage.”

This enhances existing requirements under federal Medicaid law. In order to carry out this requirement, DSS should take the following steps:

A. Identify which individuals have income above the new guidelines and notify TMA eligible participants, as follows:

- Identify, using whatever methods DSS, AHCT or any other state or federal agency has, all those whose income is greater than 150% (155% with disregards) of poverty.
- For all of these cases, review any un-reviewed documents pending in any queues in ConneCT or with Xerox, Inc. to ensure that any changes in income that might be included on such documents are taken into account in determining the household’s income level
- Identify which of these individuals found to have income in excess of the new guidelines have any earned income, based on an individualized review of sources of income
- Send notice to these individuals indicating the amount of income DSS has determined the household has, and notifying them that their regular HUSKY A is ending but they will receive a year of TMA, with identical benefits.

B. For the 1350 households/individuals who do not qualify for TMA:

- Review each case where the household does not have any earned income and where income exceeds 155% of poverty to determine whether the household might qualify under a different full or limited benefit Medicaid coverage group based on information available to the Department, including the review of all relevant medical claims data and CHNCT documents. For example, a review of information available to the Department could identify those who: (1) are pregnant,¹ (2) are over 65, blind or disabled and may have high medical bills, (3) have breast or cervical cancer, or (4) have tuberculosis. There may also be other full or limited benefit Medicaid coverage groups that the Department could identify in this way. DSS should enroll these households in the alternative coverage group where there is sufficient information to do so, placing them in a full benefit group instead of a limited benefit group wherever both options are available. For any household identified as *potentially* eligible under another coverage group, DSS should send individualized notice advising them that they no longer qualify for HUSKY A but that they might qualify for coverage on these alternative bases, indicating the verification needed to qualify under these categories and explaining the process and timeframes for establishing this eligibility.

¹ A woman on HUSKY A who is pregnant but also has earned income must be placed on TMA, not pregnancy coverage. This is required by federal law but also will ensure a somewhat longer period of continued Medicaid eligibility -- one year versus several months.

- After DSS has reviewed the 1350 cases with income over 155% of poverty but no earnings, for those cases that do not appear to qualify for any other Medicaid coverage group, DSS should send a notice telling them that their HUSKY A coverage is ending due to a change in the law. The notice should specify:
 - that if they have earned income, they might qualify for TMA;
 - the amount of income that DSS has based the decision on;
 - that they should check to see if their income and the sources of their income is as stated on the notice (and listing the kinds of income that do not count, such as child support, SSI and VA benefits);
 - a listing of other full or limited benefit Medicaid coverage groups for which they might be eligible;
 - appeal rights in the event the individual thinks the Department made a mistake and that they can keep their full benefits pending a hearing if they request a hearing by the termination date; and
 - that they may apply for subsidized insurance through a qualified health plan on the exchange and can both be on this insurance and receive coverage through a limited benefit Medicaid group for which they may qualify²
 - that children’s eligibility for Medicaid is completely unaffected

C. For all cases:

- DSS should maintain eligibility for every household that requests a hearing or contacts DSS about alternative eligibility before the termination date on the notice of action.
- Timely process any responses it receives, and not terminate anyone who timely responds in any way to any of the above notices stating they believe they still are eligible for Medicaid, under HUSKY A or alternative eligibility, until it has completed such processing in the EMS system, including by reviewing any pending un-reviewed documents in any Connect or AHCT queues
- For all individuals who are deemed **not** to be eligible for TMA, and who either do not appear to be eligible under any of these alternative categories or who are **confirmed not to have responded in any way to an individualized notice** sent out to them based on such possible alternative eligibility, consider them for the limited family planning benefit and put them on if eligible.
- For those who do **not** respond to the generalized notice but who are identified as disabled by the Department, pursuant to UPM 1005.10, termination should not occur unless and until an attempt is first made to reach the individual by telephone to confirm that they in fact do not have earned income, that a material mistake in the amount of their income was not made, and that they are not eligible under any Medicaid benefit category, including spending down to HUSKY C with medical bills.

² Section 374 also requires the Commissioner of Social Services and AHCT to work together to ensure that individuals who, after individualized review, are found not to be eligible under any full benefit Medicaid eligibility group, do not experience any gap in transitioning to a qualified health plan on the exchange: “(b) The commissioner and the Connecticut Health Insurance Exchange, established pursuant to section 38a-1081 of the general statutes, shall ensure that such parent or needy caretaker relative is given an opportunity to enroll in a qualified health plan without a gap in coverage. The Connecticut Health Insurance Exchange shall enlist the assistance of health and social services community-based organizations to contact and advise such parent or needy caretaker relative of options for health insurance coverage.”