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

[redacted] 2017
Signature confirmation

Client: [redacted]
AHCT Application: [redacted]
Request: 832548

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2017, the Health Insurance Exchange, Access Health CT ("AHCT") issued [redacted] (the "Appellant") a notice granting her Medicaid/HUSKY A ("Medicaid") medical coverage effective [redacted] 2017.

On [redacted] 2017, the Appellant filed a request with the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") to contest the effective date of her Medicaid medical coverage, requesting that her coverage be retroactively granted effective [redacted] 2017.

On [redacted] 2017, the OLCRAH issued a notice scheduling the administrative hearing for [redacted] 2017.

On [redacted] 2017, 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 ("CFR") §§ 155.505(b) and 155.510 and/or 42 CFR § 457.113, OLCRAH held an administrative hearing by telephone. The following individuals participated at the hearing:

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

The administrative hearing record closed [redacted] 2017.

STATEMENT OF ISSUE

The issue to be decided by this proceeding is whether AHCT correctly determined the effective date of the Appellant's Medicaid coverage.

FINDINGS OF FACT

1. The Appellant is married to [redacted] (the "spouse"). (Appellant's testimony)

2. The Appellant's spouse is an Italian citizen. (Appellant's Exhibit 5)

3. The Appellant is self-employed, doing business as [redacted] (Appellant's testimony)(Appellant's Exhibit 2)

4. In the period from [redacted] 2016 through [redacted] 2017, the Appellant received medical coverage through Connecticare (POS), a Qualified Health Plan, purchased through AHCT. (Appellant's Exhibit 3)(Hearing record)

5. On [redacted] 2016, the Appellant left the United States. (Appellant's testimony)

6. The Appellant expected to return to Connecticut, but did not know when she was coming back. (Appellant's testimony)

7. While the Appellant was living outside of the United States, she continued to pay her Qualified Health Plan premiums through her business account associated with [redacted]. (Appellant's Exhibit 2)(Appellant's testimony)

8. While in she was living outside of the United States, the Appellant's medical needs were met by Italian hospitals. (Appellant's testimony)

9. On [redacted] 2017, the Appellant reported to AHCT by email that she was pregnant. (Appellant's Exhibit 5)

10. On [redacted] 2017, the Appellant returned to the United States. (Appellant's testimony)

11. On [redacted] 2017, the Appellant's spouse came to the United States as a tourist, with visitor status. (Appellant's testimony)

12. The Appellant gave birth on [redacted] 2017. (AHCT's Exhibit A)(Appellant's testimony)

13. The Appellant's Qualified Health Plan paid for $10,111.15 of the $12,661.15 costs associated with the Appellant's delivery. (Appellant's Exhibit 1)

14. Hartford Healthcare has billed the Appellant $2,550.00 for costs associated with the Appellant's delivery that remained after payment was rendered by her Qualified Health Plan. (Appellant's Exhibit 1)

15. On [redacted] 2017, the Appellant filed a change reporting application with AHCT. (AHCT's Exhibit A)(Hearing summary)

16. On the [redacted] 2017 application, the Appellant listed her newborn as a member of her household; she did not list her spouse. (AHCT's Exhibit A)

17. On [redacted] 2017, AHCT granted the Appellant HUSKY A-Parents & Caretakers coverage, effective [redacted] 2017. (AHCT's Exhibit B)(AHCT's Exhibit C)

18. On [redacted] 2017, AHCT granted the Appellant's newborn HUSKY A for Children coverage, effective [redacted] 2017. (AHCT's Exhibit B)(AHCT's Exhibit C)

19. AHCT did not evaluate whether the Appellant was eligible for retroactive Medicaid coverage for [redacted] 2017, as it was prior to the date of the [redacted] 2017 application. (AHCT's representative's testimony)

20. AHCT only explores retroactive Medicaid eligibility on an initial application. (AHCT's representative's testimony)

21. The hearing record is silent as to the Appellant's household's gross income in each month from [redacted] 2017 through [redacted] 2017.

CONCLUSIONS OF LAW

1. Title 42, Code of Federal Regulations ("C.F.R.") section 430 provides, "Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services."

2. Section 17b-260 of the Connecticut General Statutes 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.

3. The Department of Social Services shall be the sole agency to determine eligibility for assistance and services under programs operated and administered by said department. Conn. Gen. Stat. § 17b-261b (a).

4. 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.

5. Exchange eligibility appeals may be conducted by—(1) 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. 45 C.F.R. § 155.505 (c)(1).

   An appeals process established under this subpart must comply with § 155.110(a). 45 C.F.R. § 155.505 (d).

   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. 45 C.F.R. § 155.110 (a).

6. Medical assistance shall be provided for any otherwise eligible person whose income, including any available support from legally liable relatives and the income of the person's spouse or dependent child, is not more than one hundred forty-three per cent, pending approval of a federal waiver applied for pursuant to subsection (e) of this section, of the benefit amount paid to a person with no income under the temporary family assistance program in the appropriate region of residence and if such person is an institutionalized individual as defined in Section 1917 of the Social Security Act, 42 USC 1396p(h)(3), and has not made an assignment or transfer or other disposition of property for less than fair market value for the purpose of establishing eligibility for benefits or assistance under this section. Any such

disposition shall be treated in accordance with Section 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of property made on behalf of an applicant or recipient or the spouse of an applicant or recipient by a guardian, conservator, person authorized to make such disposition pursuant to a power of attorney or other person so authorized by law shall be attributed to such applicant, recipient or spouse. A disposition of property ordered by a court shall be evaluated in accordance with the standards applied to any other such disposition for the purpose of determining eligibility. The commissioner shall establish the standards for eligibility for medical assistance at one hundred forty-three per cent of the benefit amount paid to a household of equal size with no income under the temporary family assistance program in the appropriate region of residence. In determining eligibility, the commissioner shall not consider as income Aid and Attendance pension benefits granted to a veteran, as defined in section 27-103, or the surviving spouse of such veteran. Except as provided in section 17b-277 and section 17b-292, the medical assistance program shall provide coverage to persons under the age of nineteen with household income up to one hundred ninety-six per cent of the federal poverty level without an asset limit and to persons under the age of nineteen, who qualify for coverage under Section 1931 of the Social Security Act, with household income not exceeding one hundred ninety-six per cent of the federal poverty level without an asset limit, and their parents and needy caretaker relatives, who qualify for coverage under Section 1931 of the Social Security Act, with household income not exceeding one hundred fifty per cent of the federal poverty level without an asset limit. Such levels shall be based on the regional differences in such benefit amount, if applicable, unless such levels based on regional differences are not in conformance with federal law. Any income in excess of the applicable amounts shall be applied as may be required by said federal law, and assistance shall be granted for the balance of the cost of authorized medical assistance. The Commissioner of Social Services shall provide applicants for assistance under this section, at the time of application, with a written statement advising them of (1) the effect of an assignment or transfer or other disposition of property on eligibility for benefits or assistance, (2) the effect that having income that exceeds the limits prescribed in this subsection will have with respect to program eligibility, and (3) the availability of, and eligibility for, services provided by the Nurturing Families Network established pursuant to section 17b-751b. For coverage dates on or after January 1, 2014, the department shall use the modified adjusted gross income financial eligibility rules set forth in Section 1902(e)(14) of the Social Security Act and the implementing regulations to determine eligibility for HUSKY A, HUSKY B and HUSKY D applicants, as defined in section 17b-290. Persons who are determined ineligible for assistance pursuant to this section shall be provided a written statement notifying such persons of their ineligibility and advising such persons of their potential eligibility for one of the other insurance affordability programs as defined in 42 CFR 435.4. Conn. Gen. Stat. § 17b-261 (a).

7. The agency must provide Medicaid to pregnant women whose household income is at or below the income standard established by the agency in its State plan, in accordance with paragraph (c) of this section. 42 C.F.R. § 435.116 (b).

The commissioner shall implement presumptive eligibility for appropriate pregnant women applicants for the Medicaid program in accordance with Section 1920 of the Social Security Act. The commissioner shall designate qualified entities to receive and determine presumptive eligibility under this section consistent with the provisions of federal law and regulations. Conn. Gen. Stat. § 17b-277 (b).

8. The agency must establish in its State plan the income standard as follows:
   (1) The minimum income standard is the higher of: (i) 133 percent of the FPL [Federal Poverty Level] for the applicable family size; or (ii) Such higher income standard up to 185 percent FPL, if any, as the State had established as of December 19, 1989 for determining eligibility for pregnant women, or, as of July 1, 1989, had authorizing legislation to do so.
   (2) The maximum income standard is the higher of—
      (i) The highest effective income level in effect under the Medicaid State plan for coverage under the sections specified at paragraph (a) of this section, or waiver of the State plan covering pregnant women, as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard in accordance with guidance issued by the secretary under section 1902 (e)(14)(A) and (E) of the Act, or
      (ii) 185 percent of the FPL. 42 C.F.R. § 435.116 (c).

   The Commissioner of Social Services shall provide, in accordance with federal law and regulations, medical assistance under the Medicaid program to needy pregnant women whose families have an income not exceeding two hundred fifty-eight percent of the federal poverty level. Conn. Gen. Stat. § 17b-277 (a).

   UPM § 2540.43 addresses Medicaid/HUSKY A for Pregnant Women with Income Under 250% of the Federal Poverty Level.

9. 42 C.F.R. § 435.403 addresses State residence.

   Requirement. The agency must provide Medicaid to eligible residents of the State, including residents who are absent from the State. The conditions under which payment for services is provided to out-of-State residents are set forth in § 431.52 of this chapter. 42 C.F.R. § 435.403 (a).

   The plan must provide that the State will establish procedures to facilitate the furnishing of medical services to individuals who are present in the State and are eligible for Medicaid under another State's plan. 42 C.F.R. § 431.52 (c).

   Who is a State resident. A resident of a State is any individual who:
   (1) Meets the conditions in paragraphs (e) through (i) of this section; or
   (2) Meets the criteria specified in an interstate agreement under paragraph (k) of this section. 42 C.F.R. § 435.403 (d).

Individuals age 21 and over. Except as provided in paragraph (f) of this section, with respect to individuals age 21 and over –

(1) For an individual not residing in an institution as defined in paragraph (b) of this section, the State of residence *is the State where the individual is living* and –
   (i) Intends to reside, including without a fixed address; or
   (ii) Has entered the State with a job commitment or seeking employment (whether or not currently employed). 42 C.F.R. § 435.403 (h).

Residency in the state is a technical eligibility requirement for all programs. This chapter provides the basis for establishing the residency of any individual. Criteria for determining when residency has been terminated is also included in this chapter. UPM § 3010.

The residency requirement for Medical Assistance is met by *living in the state* and in some instances meeting other conditions. These other conditions are based on whether or not the individual is in an institution and whether or not the individual is capable of indicating intent to remain in the state. UPM § 3010.10 (A).

10. **Cases of disputed residency.** Where two or more States cannot resolve which State is the State of residence, the State where the individual *is physically located* is the State of residence. 42. C.F.R. § 435.403 (m).

Disputed Residence. An applicant who meets the residency requirement in more than one state is entitled to prompt assistance from one state or the other. To resolve disputes the following considerations should be taken into account:

A. No durational residence requirement can be applied.
B. Residence in the state prior to entering an institution is not a requirement.
C. Any action by a state constitutes state placement except:
   1. providing basic information about another state's Medical Assistance; or
   2. providing basic information about the availability of health care services in another state.
D. If one state cannot agree to accept responsibility, the dispute must be resolved by granting assistance in the state in which the individual is physically present. UPM § 3010.25.

11. **Interstate agreements.** A State may have a written agreement with another State setting forth rules and procedures resolving cases of disputed residency. These agreements may establish criteria other than those specified in paragraphs (c) through (i) of this section, but must not include criteria that result in loss of residency in both States or that are prohibited by paragraph (j) of this section. The agreements must contain a procedure for providing Medicaid to individuals pending resolution of the case. States may use interstate agreements for purposes other than cases of disputed residency to facilitate administration of the program, and to facilitate the placement and adoption of title IV-E individuals when the child and his or her adoptive parent(s) move into another State. 42 C.F.R. § 435.403 (k).

Section 17b-56 of the Connecticut General Statutes addresses the Interstate Compact on Welfare Services. Article I provides, "The policy of the states party to this compact is to make welfare services available on a reciprocal basis under this compact and to eliminate barriers caused by restrictive residence or settlement requirements of the several states. However, it is recognized that law and policy relating generally to the provision of welfare services by a particular state should not be determined by interstate compact and will remain a matter for determination by that party state and its subdivisions. This compact shall be open for joinder by any state of the United States and the District of Columbia."

12. In the period from [redacted] 2016 through [redacted] 2017, the Appellant was not living (i.e. physically located) in Connecticut or another State in the United States.

13. With respect to the Medicaid program, the Appellant did not meet the State residency requirement at any point in the period from [redacted] 2016 through [redacted] 2017, as she was living in a foreign country.

14. The Appellant was not eligible to participate in the Medicaid program when she was living in a foreign country.

15. 42 C.F.R. § 435.3 (a) provides the basis for implementation of certain sections of the Act and public laws that mandate eligibility requirements and standards. Section 1902 (a)(34) of the Social Security Act provides for three-month retroactive eligibility.

Section 1902 (a)(34) of the Social Security Act [42 U.S.C. 1396a] notes "A State plan for medical assistance must—(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished."

The beginning date of assistance for Medicaid may be one of the following:

(A) the first day of the first, second, or third month immediately preceding the month in which the Department receives a signed application when all non-procedural eligibility requirements are met and covered medical services are received at any time during that particular month; or

(B) the first day of the month of application when all non-procedural eligibility requirements are met during that month; or

(C) the actual date in a spend-down period when all non-procedural eligibility requirements are met. For the determination of income eligibility in spend-down, refer to Income Eligibility Section 5520; or

(D) the first of the calendar month following the month in which an individual is determined eligible when granted assistance as a Qualified Medicare

Beneficiary. The month of eligibility is conserved to be the month that the Department receives all information and verification necessary to reach a decision regarding eligibility. UPM § 1560.10.

19. It cannot be determined from the hearing record whether the Appellant is eligible for Medicaid coverage for the retroactive benefit months of [redacted] 2017, [redacted] 2017, and [redacted] 2017.

DISCUSSION

The Appellant testified that she had been living outside of the United States from [redacted] 2016 through [redacted] 2017; she returned to Connecticut on [redacted] 2017. The Appellant gave birth to her newborn on [redacted] 2017.

The Appellant continued her private insurance, as purchased through the Health Insurance Exchange, AHCT, during the period that she was living outside of the United States. The Appellant noted that her medical needs were met while she was in Italy, by Italian hospitals.

The Appellant argues that she should be eligible for Medicaid medical coverage as a pregnant woman effective [redacted] 2017, the date she reported her pregnancy to AHCT by email. Her argument is unsupported by federal and state law governing the administration of the Medicaid program.

The hearing officer was unable to locate a provision in federal or state law that would permit the State of Connecticut to grant Medicaid coverage—pregnancy- or non-pregnancy-related—to an individual living in a foreign country. Medicaid coverage through Connecticut's Medicaid State Plan is available for eligible people who live in Connecticut.[1]

However, federal law allows Medicaid coverage to be granted for eligible individuals in the three months prior to the date that a Medicaid application is filed. The hearing record establishes that the Appellant filed a Medicaid change reporting application with AHCT on [redacted] 2017.

With respect to the Appellant's specific circumstances, she *may* be eligible for Medicaid coverage for the months of [redacted] 2017, [redacted] 2017 and [redacted] 2017.

If the Appellant wishes to pursue retroactive Medicaid coverage for [redacted] 2017, [redacted] 2017, and [redacted] 2017, she would have to provide AHCT with verification of her household's exact income – incorporating her self-employment income and her spouse's income as a deemor, as well as unearned income that may have been received by the household in that period – in each of those three specific months to

[1] Under limited circumstances, Medicaid coverage is available to recipients who are temporarily living in another State, provided that the other State participates in an interstate agreement with Connecticut. There are no provisions to extend Medicaid coverage for recipients temporarily living in a foreign country.

allow AHCT to determine whether she was within the income limits of the Medicaid program in each of those three specific months.

DECISION

The issue of this hearing is REMANDED to AHCT for the purpose of evaluating whether the Appellant was eligible for Medicaid coverage in the three months immediate preceding her [redacted] 2017 change reporting application: i.e. [redacted] 2017, [redacted] 2017, and [redacted] 2017.

ORDER

1. AHCT will evaluate whether the Appellant was eligible for Medicaid coverage in each of the following three retroactive benefit months: [redacted] 2017, [redacted] 2017, and [redacted] 2017.

   As part of its evaluation, AHCT must follow the non-financial, financial, and verification requirements of the Medicaid program. AHCT must assess the Appellant's household composition; must review the income-deeming rules for an ineligible spouse; and must require verification from the Appellant of her household's income in [redacted] 2017, [redacted] 2017, and [redacted] 2017.

2. AHCT will notify the Appellant in writing of what verifications she must provide to AHCT in order for potential eligibility to be evaluated for [redacted] 2017, [redacted] 2017, and [redacted] 2017. AHCT will give the Appellant a deadline that is in compliance with Medicaid procedures to submit the necessary verification.

3. Within 21 calendar days of the date of this decision, or [redacted] 2018, documentation of compliance with this order is due to the undersigned.

Eva Tar-electronic signature
Eva Tar
Hearing Officer

cc: Krystal Sherman, 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.