STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT 06106-5033

[redacted] **2022**
Signature Confirmation

Case # [redacted]
Client ID # [redacted]
Request # 190838

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2021, the Health Insurance Exchange, Access Health CT (Access Health) sent [redacted] (the "Appellant") a Notice of Action ("NOA") granting her application for medical benefits under the Husky A Medicaid for Parents and Caretakers effective [redacted] 2022.

On [redacted] 2022, the Appellant requested an Administrative Hearing to contest the Department's determination of the effective date of Medicaid coverage.

On [redacted] 2022, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the Administrative Hearing for [redacted] 2022.

On [redacted] 2022, the Appellant requested to reschedule the Administrative Hearing.

On [redacted] 2022, the OLCRAH issued a notice rescheduling the Administrative Hearing for [redacted] 2022.

On [redacted] 2022, the Appellant did not attend the scheduled Administrative Hearing.

On [redacted] 2022, the Appellant requested to reschedule the Administrative Hearing.

On [redacted] 2022, the OLCRAH issued a notice rescheduling the Administrative Hearing for [redacted] 2022.

On [redacted] 2022, in accordance with sections 17b-60, 17-61 and 4-176e to 4-184 inclusive, of the Connecticut General Statutes, and 45 C.F.R. §§ 155.505 (b) and 155.510 the OLCRAH held an Administrative Hearing by telephone.

The following individuals participated in the hearing:

[redacted] Appellant
Debra Henry, Access Health Representative
Jessica Gulianello, Hearing Officer

The hearing record remained open for the submission of additional documents from the Department. Additional information was received on [redacted] 2022, and the hearing record closed accordingly.

STATEMENT OF THE ISSUE

The issue to be decided is whether Access Health correctly determined the Appellant eligible for Husky A Medicaid with an effective date of [redacted] 2022.

FINDINGS OF FACT

1. The Appellant [redacted], residing [redacted], and receiving Medicaid medical coverage from [redacted]. (Appellant's Testimony)

2. The Appellant moved from [redacted] and obtained [redacted] residency as of [redacted] 2021. (Appellant's Testimony)

3. The Appellant continued to travel to [redacted] for her routine medical appointments. (Appellant's Testimony)

4. On [redacted] 2021, the Appellant [redacted] gave birth to her son, [redacted] at [redacted] Hospital. (Appellant's Testimony)

5. On [redacted] 2021, the Appellant applied for medical insurance coverage online through Access Health. The Appellant requested coverage for herself and her newborn son. (Exhibit 1: Application, [redacted]/2021, Hearing Record)

6. On [redacted] 2021, Access Health sent the Appellant 1301: NOA. The NOA reflected [redacted] was determined eligible for Husky A: Medicaid for Children with a coverage start date of [redacted] 2021, and the Appellant was determined

eligible for Husky A: Pregnancy Medicaid with a coverage start date of [redacted] 2022. (Exhibit 2: 1301 NOA, [redacted]/2021)

7. The Appellant's Medicaid coverage in the state of [redacted] ended on or about [redacted] 2021. (Appellant's Testimony)

8. The Department of Social Services ("The Department") granted the Appellant's Husky A: Medicaid coverage with a start date of [redacted] 2022, in the eligibility management system, ("ImpaCT"). (Hearing Record, Access Health Testimony)

9. On [redacted] 2022, the Appellant submitted a change [redacted] through Access Health again requesting medical coverage for herself and her newborn son. (Exhibit 1, Application, [redacted] 2022, Hearing Record)

10. On [redacted] 2022, Access Health sent the Appellant 1301: NOA reflecting [redacted] remained eligible for Husky A: Medicaid for Children with a coverage start date of [redacted] 2021. The NOA reflected the Appellant was determined eligible for Husky A: Pregnancy Medicaid with a coverage start date of [redacted] 2022. (Exhibit 2: NOA, [redacted] 2022, Hearing Record)

11. The Husky A Medicaid medical coverage for the Appellant was granted as of [redacted] 2022, and remains active to date with no interim lapse in benefits. (Access Health Testimony).

12. Access Health CT argued the Appellant was ineligible for Medicaid [redacted] during the month of application [redacted] 2021) due to receipt of Medicaid from [redacted]. (Access Health Testimony)

13. Access Health does not dispute that the Appellant was income eligible for Husky A Medicaid coverage at the time of the [redacted] 2021 application and that she remains income eligible for the Medicaid coverage group. (Access Health Testimony)

14. The Appellant is contesting the effective date of her eligibility for Husky A Pregnancy Medicaid coverage by Access Health. The Appellant is not contesting the effective date of Husky A: Medicaid coverage for her son, [redacted]. (Appellant's Testimony)

15. The issuance of this decision is timely under Connecticut General Statutes (Conn. Gen. Stat.") 17b-61(a), which requires that a decision be rendered within 90 days of the request for an Administrative Hearing. The Appellant requested an Administrative Hearing on [redacted] 2022, with the decision due no later than [redacted] 2022. However, the time for rendering a final decision shall be extended whenever the aggrieved person requests or agrees to an extension, or when the commissioner documents an administrative or other extenuating circumstance beyond the commissioner's control. In the present case, the Appellant was granted

two extensions that lengthened the due date by [redacted], with this decision due no later than [redacted] 2022. (Hearing Record)

CONCLUSIONS OF LAW

1. Conn. Gen. Stat. § 17b-2 provides the Department of Social Services is designated as the state agency for the administration of (6) the Medicaid program pursuant to Title XIX of the Social Security Act.

2. Sec. 17b-260 provides for the 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.

   The Department has the authority to administer and determine eligibility for the Medicaid program.

3. 45 C.F.R. § 155.110(a) provides the following: 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.

   Access Health is the Department's designated state entity to administer the Health Insurance Exchange Program.

4. 45 C.F.R § 155.505(c)(1) provides the following: 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.

5. 45 C.F.R § 155.505(d) provides the Following: An appeals process established under this subpart must comply with § 155.110(a).

6. 45 C.F.R § 155.110(a)(2) provides the following: 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: the State Medicaid agency, or any other State agency that meets the qualification of paragraph (a)(1) of this section.

Access Health has the authority to participate in Administrative Hearings.

7. 42 C.F.R § 435.956(e) provides the following: Pregnancy. The agency must accept self-attestation of pregnancy unless the State has information that is not reasonably compatible with such attestation, subject to the requirements of § 435.952 of this subpart.

The Appellant was pregnant and gave birth in [redacted] 2021 during the same month that she applied for medical coverage.

8. 42 C.F.R § 435.956(c)(1) provides the following: The agency may verify State residency in accordance with § 435.945(a) of this subpart or through other reasonable verification procedures consistent with the requirements in § 435.952 of this subpart.

42 C.F.R § 435.945(a) provides the following: Except where the law requires other procedures (such as for citizenship and immigration status information), the agency may accept attestation of information needed to determine the eligibility of an individual for Medicaid (either self-attestation by the individual or attestation by an adult who is in the applicant's household, as defined in § 435.603(f) of this part, or family, as defined in section 36B(d)(1) of the Internal Revenue Code, an authorized representative, or, if the individual is a minor or incapacitated, someone acting responsibly for the individual) without requiring further information (including documentation) from the individual.

The Appellant testified that she was [redacted] at the time of said application.

9. 42 C.F.R § 435.603 provides the following: Application of modified adjusted gross income (MAGI).(a) Basis, scope, and implementation. (1) This section implements section 1902(e)(14) of the Act. (2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section. (3)

In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid coverage to begin on or before December 31, 2013, application of the financial methodologies set forth in this section will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility for such individual under § 435.916 of this part, whichever is later. (b) Definitions. For purposes of this section - Child means a natural or biological, adopted or step child. Code means the Internal Revenue Code. Family size means the number of persons counted as members of an individual's household. In the case of determining the family size of a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. In the case of determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted, at State option, as either 1 or 2 person(s) or as herself plus the number of children she is expected to deliver. Parent means a natural or biological, adopted or step parent. Sibling means natural or biological, adopted, half, or step sibling. Tax dependent has the meaning provided in § 435.4 of this part. (c) Basic rule. Except as specified in paragraph (i), (j), and (k) of this section, the agency must determine financial eligibility for Medicaid based on “household income” as defined in paragraph (d) of this section. (d) Household income - (1) General rule. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.

42 C.F.R § 435.831(b) provides the following: Determining countable income. For purposes of determining medically needy eligibility under this part, the agency must determine an individual's countable income as follows: (1) For individuals under age 21, pregnant women, and parents and other caretaker relatives, the agency may apply - (i) The AFDC methodologies in effect in the State as of August 16, 1996, consistent with § 435.601 (relating to financial methodologies for non-MAGI eligibility determinations) and § 435.602 (relating to financial responsibility of relatives and other individuals for non-MAGI eligibility determinations); or (ii) The MAGI-based methodologies defined in § 435.603(b) through (f). If the agency applies the MAGI-based methodologies defined in § 435.603(b) through (f), the agency must comply with the terms of § 435.602, except that in applying § 435.602(a)(2)(ii) to individuals under age 21, the agency may, at State option, include all parents as defined in § 435.603(b) (including stepparents) who are living with the individual in the individual's household for purposes of determining household income and family size, without regard to whether the parent's income and resources would be counted under the State's approved State plan under title IV-A of the Act in effect as of July 16, 1996, if the individual were a dependent child under such State plan.

42 C.F.R § 435.603(h)(1) provides the following: Applicants and new enrollees. Financial eligibility for Medicaid for applicants, and other individuals not receiving

Medicaid benefits at the point at which eligibility for Medicaid is being determined, must be based on current monthly household income and family size.

Access Health determined the Appellant's countable MAGI was below the Husky A Medicaid income limits for the household size.

10. 42 C.F.R § 435.915(a)(1)(2)(b) provides the following: The agency must make eligibility for Medicaid effective no later than the third month before the month of application if the individual (1) Received Medicaid services, at any time during that period, of a type covered under the plan; and (2) Would have been eligible for Medicaid at the time he received the services if he had applied (or someone had applied for him), regardless of whether the individual is alive when application for Medicaid is made.(b) The agency may make eligibility for Medicaid effective on the first day of a month if an individual was eligible at any time during that month. (c) The State plan must specify the date on which eligibility will be made effective.

11. 45 C.F.R § 435.1200 provides the following: Medicaid agency responsibilities for a coordinated eligibility and enrollment process with other insurance affordability programs. (a) Statutory basis, purpose, and definitions. (1) Statutory basis and purpose. This section implements section 1943(b)(3) of the Act as added by section 2201 of the Affordable Care Act to ensure coordinated eligibility and enrollment among insurance affordability programs. (2) Definitions. (i) Combined eligibility notice has the meaning as provided in § 435.4. (ii) Coordinated content has the meaning as provided in § 435.4. (iii) Joint fair hearing request has the meaning provided in § 431.201 of this chapter. (b) General requirements and definitions. The State Medicaid agency must - (1) Fulfill the responsibilities set forth in paragraphs (d) through (h) of this section and, if applicable, paragraph (c) of this section. (2) Certify for the Exchange and other insurance affordability programs the criteria applied in determining Medicaid eligibility. (3) Enter into and, upon request, provide to the Secretary one or more agreements with the Exchange, Exchange appeals entity and the agencies administering other insurance affordability programs as are necessary to fulfill the requirements of this section, including a clear delineation of the responsibilities of each program to - (i) Minimize burden on individuals seeking to obtain or renew eligibility or to appeal a determination of eligibility for enrollment in a QHP or for one or more insurance affordability program; (ii) Ensure compliance with paragraphs (d) through (h) of this section and, if applicable, paragraph (c) of this section; (iii) Ensure prompt determinations of eligibility and enrollment in the appropriate program without undue delay, consistent with timeliness standards established under § 435.912, based on the date the application is submitted to any insurance affordability program; (iv) Provide for a combined eligibility notice and opportunity to submit a joint fair hearing request, consistent with paragraphs (g) and (h) of this section;

and (v) If the agency has delegated authority to conduct fair hearings to the Exchange or Exchange appeals entity under § 431.10(c)(1)(ii) of this chapter, provide for a combined appeals decision by the Exchange or Exchange appeals entity for individuals who requested an appeal of an Exchange-related determination in accordance with 45 CFR part155 subpart F and a fair hearing of a denial of Medicaid eligibility which is conducted by the Exchange or Exchange appeals entity. (c) Provision of Medicaid for individuals found eligible for Medicaid by another insurance affordability program. If the agency has entered into an agreement in accordance with § 431.10(d) of this chapter under which the Exchange or other insurance affordability program makes final determinations of Medicaid eligibility, for each individual determined so eligble by the Exchange (including as a result of a decision made by the Exchange or Exchange appeals entity in accordance with paragraph (g)(6) or (7)(i)(A) of this section) or other program, the agency must - (1) Establish procedures to receive, via secure electronic interface, the electronic account containing the determination of Medicaid eligibility; (2) Comply with the provisions of § 435.911 of this part to the same extent as if the application had been submitted to the Medicaid agency; and (3) Comply with the provisions of § 431.10 of this subchapter to ensure it maintains oversight for the Medicaid program. (d) Transfer from other insurance affordability programs to the State Medicaid agency. For individuals for whom another insurance affordability program has not made a determination of Medicaid eligibility, but who have been assessed by such program (including as a result of a decision made by the Exchange appeals entity) as potentially Medicaid eligible, and for individuals not so assessed, but who otherwise request a full determination by the Medicaid agency, the agency must - (1) Accept, via secure electronic interface, the electronic account for the individual and notify such program of the receipt of the electronic account; (2) Not request information or documentation from the individual in the individual's electronic account, or provided to the agency by another insurance affordability program or appeals entity; (3) Promptly and without undue delay, consistent with timeliness standards established under § 435.912, determine the Medicaid eligibility of the individual, in accordance with § 435.911, without requiring submission of another application and, for individuals determined not eligible for Medicaid, comply with paragraph (e) of this section as if the individual had submitted an application to the agency; (4) Accept any finding relating to a criterion of eligibility made by such program or appeals entity, without further verification, if such finding was made in accordance with policies and procedures which are the same as those applied by the agency or approved by it in the agreement described in paragraph (b)(3) of this section; and (5) Notify such program of the final determination of the individual's eligibility or ineligibility for Medicaid. (e) Evaluation of eligibility for other insurance affordability programs - (1)

Individuals determined not eligible for Medicaid. For each individual who submits an application or renewal to the agency which includes sufficient information to determine Medicaid eligibility, or whose eligibility is being renewed in accordance to a change in circumstance in accordance with § 435.916(d), and whom the agency determines is not eligible for Medicaid, and for each individual determined ineligible for Medicaid in accordance with a fair hearing under subpart E of part 431 of this chapter, the agency must promptly and without undue delay, consistent with timeliness standards established under § 435.912, determine potential eligibility for, and, as appropriate, transfer via a secure electronic interface the individual's electronic account to, other insurance affordability programs.

12. 42 CFR 435.917(b)(1) provides the following: Notice of approved eligibility. Any notice of an approval of Medicaid eligibility must include, but is not limited to, clear statements containing the following information - (i) The basis and effective date of eligibility; (ii) The circumstances under which the individual must report, and procedures for reporting, any changes that may affect the individual's eligibility; (iii) If applicable, the amount of medical expenses which must be incurred to establish eligibility in accordance with § 435.121 or § 435.831. (iv) Basic information on the level of benefits and services available based on the individual's eligibility, including, if applicable - (A) The differences in coverage available to individuals enrolled in benchmark or benchmark-equivalent coverage or in an Alternative Benefits Plan and coverage available to individuals described in § 440.315 of this chapter (relating to exemptions from mandatory enrollment in benchmark or benchmark-equivalent coverage); (B) A description of any premiums and cost sharing required under Part 447 Subpart A of this chapter; (C) An explanation of how to receive additional detailed information on benefits and financial responsibilities; and (D) An explanation of any right to appeal the eligibility status or level of benefits and services approved.

13. Uniform Policy Manual (UPM) § 1560.10 (A)(B) provides the following: 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;

14. UPM § 3030.05 provides the following: There is a technical requirement prohibiting the receipt of benefits from two financial assistance programs at the same time. In addition, AABD must be received concurrently with SSI or some countable income other than GA. The Food Stamp program also requires discontinuance of Food Stamp benefits in one state before assistance can be granted in another. Medicaid has no comparable requirements. Programs that can and cannot be received

concurrently are as follows: (C) MA: An individual who is eligible for MA may receive MA concurrently with any of the following: 1. Food Stamps; 2. General Assistance; 3. AFDC; 4. AABD;

Access Health incorrectly determined the Appellant's beginning date of assistance under the Husky A Medicaid program as [redacted] 2022.

Access Health is responsible for coordinating Medicaid eligibility and the enrollment process of individuals inclusive with the insurance affordability programs in other states.

Regulation and policy do not limit an individual from participating in Medicaid based solely on a coexisting determination of eligibility by another state.

Access Health is responsible to ensure individuals who are determined eligible for Medicaid are enrolled in coverage based on the date of application and entitlement without undue delay.

DECISION

The Appellant's appeal is GRANTED

ORDER

1. **Access Health will grant the Husky A Medicaid coverage for the Appellant with an effective start date of [redacted] 2021.**
2. **Access Health will refer the application to the Department of Social Services to ensure Husky A Medicaid coverage is active in ImpaCT and the [redacted] effective [redacted] 2021.**
3. **Compliance with this order should be forwarded to the undersigned no later than 21 days from the date of this decision.**

Jessica Gulianello

Jessica Gulianello
Hearing Officer

Cc: Health Insurance Exchange; Access Health CT

APTC/CSR

Right to Appeal

For APTC or CSR eligibility determinations, the Appellant has the right to appeal to the United States Department of Health and Human Services (HHS) within 30 days of the date of this decision. To obtain an Appeal Request Form, go to https://www.healthcare.gov/can-i-appeal-a-marketplace-decision/ or call 1-800-318-2596 (TTY: 1-855-889-4325). HHS will let the Appellant know what it decides within 90 days of the appeal request. There is no right to judicial review of the decision by HHS.

There is no right to request reconsideration for denials or reductions of Advanced Primary Tax Credits (APTC) or Cost Sharing Reduction (CSR).

MEDICAID AND 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, 25 Sigourney Street, Hartford, CT 06106.

There is no right to request reconsideration for denials or reductions of Advanced Primary Tax Credits (APTC) or Cost Sharing Reduction (CSR).

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, 25 Sigourney Street, Hartford, CT 06106. 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 is 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.