**STATE OF CONNECTICUT**

**DEPARTMENT OF SOCIAL SERVICES**
**OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS**
**55 FARMINGTON AVENUE**
**HARTFORD, CT 06105-3725**

[redacted] 2022
Signature Confirmation

Client ID [redacted]
Case ID [redacted]
Request # 194737

## NOTICE OF DECISION

## PARTY

[redacted]

## PROCEDURAL BACKGROUND

On [redacted] 2022, the Health Insurance Exchange, Access Health CT ("AHCT"), sent [redacted] (the "Appellant") a Notice of Action ("NOA) stating medical coverage under the Husky A – Parents and Caretakers begins [redacted] 2022.

On [redacted] 2022, the Appellant requested an administrative hearing to contest the AHCT's failure to activate healthcare coverage under the Husky A for the period [redacted] 2021 through [redacted] 2021.

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, in accordance with sections 17b-60, 17b-264 and 4-176e to 4- 189, inclusive, of the Connecticut General Statutes, Chapter 45 Code of Federal Regulations ("CFR") §§ 155.505(b) and 155.510 and/or 42 CFR § 457.1130, OLCRAH held an administrative hearing by telephone.

The following individuals called in for the hearing:

[redacted], Appellant
Debra Henry, AHCT Representative
Lisa Nyren, Fair Hearing Officer

## STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT's decision to deny the Appellant's request for retroactive medical coverage under the Husky A program to cover medical services received in [redacted] 2021 was correct.

## FINDINGS OF FACT

1. On [redacted] 2021, the Appellant's medical coverage under the Husky D Medicaid program ended. (AHCT Representative's Testimony)

2. On [redacted] 2022, the Appellant completed an application for medical coverage with AHCT via telephone requesting coverage for herself. The Appellant did not request retroactive medical coverage. (Stipulated)

3. On [redacted] 2022, AHCT approved medical coverage for the Appellant under the Husky A – Parents and Caretakers program effective [redacted] 2022. (Stipulated)

4. Between the end of [redacted] 2022 and the beginning of [redacted] 2022, the Appellant received a billing statement from her therapist for services rendered in [redacted] 2021 because Medicaid denied the claim. (Appellant's Testimony)

5. The Appellant reached out to the Department of Social Services ("DSS"), AHCT, and her therapist regarding unpaid medical bills and was instructed to send the bills to [redacted] for payment. [redacted] denied payment. (Appellant's Testimony)

6. On [redacted] 2022, the Appellant submitted a request for an administrative hearing requesting medical coverage for [redacted] 2021 to pay for medical services she received in [redacted] 2021 when her medical coverage lapsed. (Appellant's Testimony)

7. AHCT did not evaluate whether the Appellant was eligible for retroactive medical coverage under the Husky A program for [redacted] 2021. (Department Representative's Testimony)

8. AHCT escalated the issue concerning eligibility for retroactive medical coverage to DSS. AHCT has not received a response from DSS. (AHCT Representative's Testimony)

9. 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] 2022. Therefore, this decision is due not later than [redacted] 2022.

## CONCLUSIONS OF LAW

1. Section 17b-260 of the Connecticut General Statutes ("Conn. Gen. Stat.") provides as follows:

   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. "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)

3. State statute provides as follows:

   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

4. Title 45 Section 155.110(a) of the Code of Federal Regulations ("C.F.R.") provides as follows:

   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 qualification of paragraph (a)(1) of this section.

Federal regulation provides as follows:

Exchange eligibility appeals may be conducted by a State Exchange appeals entity, or an eligible entity described in paragraph (d) or 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)

**AHCT is the State of Connecticut's health insurance exchange where consumers can enroll in affordable healthcare plans which includes medical coverage under Husky A programs.**

5. Federal regulation provides as follows:

This section implements sections 1931(b) and (d) of the Act.

The agency must provide Medicaid to parents and other caretaker relatives, as defined in § 435.4, and, if living with such parent or other caretaker relative, his or her spouse, whose household income is at or below the income standard established by the agency in the State plan, in accordance with paragraph (c) of this section.

42 C.F.R. § 435.110(a) and (b)

State statute provides as follows:

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-five 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. § 261(a)

6. Federal regulation provides in pertinent part as follows:

This part implements the following sections of the Act and public laws that mandate eligibility requirements and standards: 1902(a)(34) Three-month retroactive eligibility. 42 C.F.R.§ 435.3(a)

Section 1902(a)(34) of the Social Security Act [42 U.S.C. 1396a] provides as follows:

A State plan for medical assistance must-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.

Federal regulation provides as follows:

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.

42 C.F.R. § 435.915(a)

"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." 42 C.F.R.§ 435.915(b)

The department's uniform policy manual is the equivalent of a 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))

Section 1560.10(A) of the Uniform Policy Manual provides as follows:

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

**AHCT incorrectly denied the Appellant's request for retroactive medical coverage under the Husky A program for [redacted] 2021. Federal regulation does not place a time limit when a recipient can request retroactive coverage, rather federal regulation states "the agency must make eligibility for Medicaid effective no later than the third month before the month of application if the individual would have been eligible for Medicaid at the time he received the services if he had applied..." Based on the hearing record whether the Appellant made a request for retroactive medical coverage prior to the date of her hearing request cannot be determined, however, AHCT became aware of the request upon receipt of the Appellant's hearing request and failed to act on it. Based on federal regulation, state statutes, and DSS policy, there is nothing preventing AHCT from making an eligibility determination on behalf of the Appellant for Husky A coverage for [redacted] 2021.**

## DECISION

The Appellant's appeal is granted.

## ORDER

1. AHCT will make a determination of eligibility for retroactive medical coverage under the Husky A program effective [redacted] 2021 for the Appellant.

2. AHCT will notify the Appellant in writing of what verifications she must provide to AHCT for Husky A eligibility to be evaluated for [redacted] 2021, as appropriate, and allow the Appellant a minimum of 10-days to submit such verifications.

3. Compliance is due within 21-days of the date of this decision.

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Lisa A. Nyren
Fair Hearing Officer

CC: Becky Brown, AHCT
Mike Towers, AHCT
Debra Henry, 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, 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 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.