

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

██████████ 2020  
Signature Confirmation

Client ID # ██████████  
Case ID # ██████████  
Request # 155195

**NOTICE OF DECISION**

**PARTY**

██████████  
████████████████████  
██

**PROCEDURAL BACKGROUND**

On ██████████ 2020, The Health Insurance Exchange, Access Health CT (“AHCT”) issued a Notice of Action (“NOA”) to ██████████ (the “Appellant”) that denied HUSKY A Medicaid healthcare coverage for ██████████, (the “Appellant’s spouse”) because she has not been a permanent resident for five years or more.

On ██████████, 2020, the Appellant requested a hearing to contest the denial of the Medicaid/HUSKY A coverage.

On ██████████, 2020, the Office of Legal Counsel, Regulations, and Administrative Hearings (“OLCRAH”) issued a notice scheduling the administrative hearing for ██████████, 2020.

On ██████████ 2020, the Appellant requested to reschedule the administrative hearing.

On ██████████ 2020, OLCRAH issued a notice rescheduling the administrative hearing for ██████████ 2020.

On ██████████ 2020, 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 in the hearing:

██████████, Appellant  
Debra Henry, AHCT Representative  
Veronica King, Hearing Officer

### **STATEMENT OF THE ISSUE**

The issue to be decided is whether AHCT correctly denied the Medicaid/HUSKY A healthcare coverage for ██████████ for failing to meet permanent residency requirements.

### **FINDINGS OF FACT**

1. The Appellant's spouse became a legal permanent resident of the United States ("US") on ██████████ 2000. (Ex. A: Permanent Resident Card)
2. The Appellant and his spouse and child were active on Medicaid/HUSKY A healthcare coverage. (Appellant's testimony, AHCT's testimony)
3. On ██████████, 2020, AHCT updated the Appellant's healthcare application. The application reflected that the Appellant was a naturalized citizen, his spouse was a legal permanent resident with a minimum of five years at that status, and the son was classified as a US citizen. (Ex. 1: Application ██████████)
4. On ██████████ 2020, AHCT sent the Appellant a Notice of Action which stated that the Appellant and his son would continue to receive Medicaid/HUSKY A medical coverage and his spouse would be eligible to purchase a Qualified Health Plan ("QHP") with an Advanced Premium Tax Credit ("APTC"). The Notice stated that the Appellant's spouse would lose eligibility for HUSKY A Medicaid coverage effective ██████████, 2020 because she has not been a legal permanent resident for a minimum of five years. (Ex. 3: Notice of Action ██████████20)
5. AHCT is in agreement that the Appellant's spouse has been a legal permanent resident for a minimum of five years and meets the citizenship eligibility requirement of the HUSKY A program. (Department's testimony, Hearing summary)
6. AHCT's discontinuance of the Appellant's spouse's HUSKY A was an error. AHCT has attempted to correct that error but cannot due to a system issue. (Department's testimony)
7. The issuance of this decision is timely under section 17b-61(a) of Connecticut General Statutes, 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], 2020. This decision, therefore, was due no later than [REDACTED] 2020. The hearing, however, which was originally scheduled for [REDACTED] 2020, was rescheduled for [REDACTED] 2020, at the request of the Appellant, which caused a 22-day delay. Because this 22-day delay resulted from the Appellant's request, this decision is not due until [REDACTED] 2020, and is therefore timely.(Hearing Record)

### **CONCLUSIONS OF LAW**

1. Section 17b-260 of the Connecticut General Statutes ("CGS") provides for acceptance of federal grants for medical assistance. The Commissioner of Social Services is authorized to take advantage of the medical assistance programs provided in Title XIX, entitled "Grants to States for Medical Assistance Programs", contained in the Social Security Amendments of 1965 and may administer the same in accordance with the requirements provided therein, including the waiving, with respect to the amount paid for medical care, of provisions concerning recovery from beneficiaries or their estates, charges and recoveries against legally liable relatives, and liens against property of beneficiaries.
2. Section 17b-264 of the CGS provides for the extension of other public assistance provisions. All of the provisions of sections 17b-22, 17b-75 to 17b-77, inclusive, 17b-79 to 17b-83, inclusive, 17b-85 to 17b-103, inclusive, and 17b-600 to 17b-604, inclusive, are extended to the medical assistance program except such provisions as are inconsistent with federal law and regulations governing Title XIX of the Social Security Amendments of 1965 and sections 17b-260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, and 17b-357 to 17b-361, inclusive.
3. Title 45 of the Code of Federal Regulations ("CFR") § 155.505(c)(1) provides that Exchange eligibility appeals may be conducted by a State Exchange appeals entity or an eligible entity described in paragraph (d) of this section that is designated by the Exchange, if the Exchange establishes an appeals process in accordance with the requirements of this subpart.
4. 45 CFR § 155.505(d) provides that an appeals process established under this subpart must comply with § 155.110(a).
5. 45 CFR § 155.110(a) provides that the State may elect to authorize an Exchange established by the State to enter into an agreement with an eligible entity to carry out one or more responsibilities of the Exchange. Eligible entities are: (1) an entity: (i) Incorporated under, and subject to the laws of one or more States; (ii) That has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and (iii) Is not a health insurance issuer or treated as a health insurance issuer under

subsection (a) or (b) of section 52 of the Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or (2) The State Medicaid agency, or any other State agency that meets the qualifications of paragraph (a)(1) of this section.

6. Title 42 CFR §435.406 provides for Citizenship and non-citizen eligibility.

(a) The agency must provide Medicaid to otherwise eligible individuals who are—

(1) Citizens and nationals of the United States, provided that—

(i) The individual has made a declaration of United States citizenship, as defined in §435.4, or an individual described in paragraph (a)(3) of this section has made such declaration on the individual's behalf, and such status is verified in accordance with paragraph (c) of this section; and

(ii) For purposes of the declaration and citizenship verification requirements discussed in paragraphs (a)(1)(i) of this section, an individual includes applicants under a section 1115 demonstration (including a family planning demonstration project) for which a State receives Federal financial participation in its expenditures.

(iii) The following groups of individuals are exempt from the requirement to provide documentation to verify citizenship in paragraph (c) of this section:

(A) Individuals receiving SSI benefits under title XVI of the Act.

(B) Individuals entitled to or enrolled in any part of Medicare.

(C) Individuals receiving disability insurance benefits under section 223 of the Act or monthly benefits under section 202 of the Act, based on the individual's disability (as defined in section 223(d) of the Act).

(D) Individuals who are in foster care and who are assisted under Title IV-B of the Act, and individuals who are beneficiaries of foster care maintenance or adoption assistance payments under Title IV-E of the Act.

(E)(1) Individuals who are or were deemed eligible for Medicaid in the State under §435.117 or §457.360 of this chapter on or after July 1, 2006, based on being born to a pregnant woman eligible under the State's Medicaid or CHIP state plan or waiver of such plan;

(2) At State option, individuals who were deemed eligible for coverage under §435.117 or §457.360 of this chapter in another State on or after July 1, 2006, provided that the agency verifies such deemed eligibility.

(2)(i) Except as specified in 8 U.S.C. 1612(b)(1) (permitting States an option with respect to coverage of certain qualified non-citizens), qualified non-citizens as described in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) (including qualified non-citizens subject to the 5-year bar) who have provided satisfactory documentary evidence of Qualified Non-Citizen status, which status has been verified with the Department of Homeland Security (DHS) under a declaration required by section 1137(d) of the Act that the applicant or beneficiary is a non-citizen in a satisfactory immigration status.

(ii) The eligibility of qualified non-citizens who are subject to the 5-year bar in 8 U.S.C. 1613 is limited to the benefits described in paragraph (b) of this section.

(3) For purposes of paragraphs (a)(1) and (2), of this section, a declaration of citizenship or satisfactory immigration status may be provided, in writing and under penalty of perjury, by an adult member of the individual's household, an authorized representative, as defined in §435.923, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant provided that such individual attests to having knowledge of the individual's status.

(b) The agency must provide payment for the services described in §440.255(c) of this chapter to residents of the State who otherwise meet the eligibility requirements of the State plan (except for receipt of AFDC, SSI, or State Supplementary payments) who are qualified non-citizens subject to the 5-year bar or who are non-qualified non-citizens who meet all Medicaid eligibility criteria, except non-qualified non-citizens need not present a social security number or document immigration status.

(c) The agency must verify the declaration of citizenship or satisfactory immigration status under paragraph (a)(1) or (2) of this section in accordance with §435.956

7. AHCT incorrectly determined the Appellant's spouse is not an eligible non-citizen.

8. AHCT incorrectly discontinued the Medicaid/HUSKY A healthcare coverage.

**DECISION**

The Appellant's appeal is **GRANTED**.

**ORDER**

1. AHCT will reinstate the Appellant's spouse's HUSKY A Medicaid retroactive to [REDACTED] 2020, the date of discontinuance.
2. Proof of compliance with this order will be forwarded to the undersigned within 10 days of this decision, [REDACTED] 2020.

*Marci Ostroski*

---

Marci Ostroski  
Hearing Officer  
On behalf of  
Veronica King  
Hearing Officer

Pc: Debra Henry, Appeals Coordinator, Health Insurance Exchange Access Health CT  
Becky Brown, Mike Towers, Health Insurance Exchange, Access Health CT

**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.