STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL REGULATION AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CONNECTICUT 06105-3730

[redacted], 2024
Signature Confirmation

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

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted], 2024, Access Health Connecticut ("AHCT") sent [redacted] (the "Appellant") a notice of action closing his HUSKY A medical assistance effective [redacted], 2024.

On [redacted], 2024, the Appellant requested an administrative hearing to contest AHCT's closure of his HUSKY A medical assistance.

On [redacted], 2024, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted], 2024.

On [redacted], 2024, in accordance with sections 17b-60, 17b-61, and 4-176e to 4-184, inclusive, of the Connecticut General Statutes, the OLCRAH held an administrative hearing. The following individuals participated in the hearing:

[redacted], Appellant
[redacted], Appellant's son and translator
Cathy Davis, AHCT's Representative
Joseph Davey, Administrative Hearing Officer

The hearing record remained open until [redacted], 2024, for the submission of additional information from the Appellant and the Department. Information was received from both parties and the record closed on [redacted], 2024.

STATEMENT OF THE ISSUE

The issue is whether AHCT's closure of the Appellant's HUSKY A medical coverage was correct.

FINDING OF FACTS

1. The Appellant is [redacted] ([redacted]) years old (DOB [redacted]) and lives with his spouse and four minor children. (Exhibit 2: AHCT application dated [redacted], Exhibit 3: Eligibility Determination Results page screenshot, Appellant's testimony)

2. On or about [redacted], 2021, the Appellant was admitted to the United States from Afghanistan under a Special Immigrant Visa ("SIV") as a Special Immigrant Parolee. The Appellant's initial Employment Authorization card displayed a *"Valid From"* date of [redacted], 2021, an expiration date of [redacted], 2023, and a C11 Category Code. (Appellant's Exhibit A: U.S. Department of State National Visa Center and U.S. Embassy letters, Appellant's Exhibit B: U.S. Employment Authorization cards, Hearing Record)

3. On [redacted], 2021, the Appellant applied for and was granted Medicaid in Connecticut. (Department's testimony)

4. In [redacted] 2023, the Appellant was issued a new Employment Authorization card which displayed a *"Valid From"* date of [redacted], 2023, an expiration date of [redacted], 2024, and a C11 Category code. (Appellant's Exhibit A, Appellant's Exhibit B)

5. On [redacted], 2024, AHCT sent the Appellant form 1305 which stated in relevant part *"Every year, Access Health CT (AHCT) and the Department of Social Services (DSS) must determine if you are qualified to get another year of HUSKY Health coverage…We could not renew your coverage without some updates to your application. Please contact Access Health CT to renew your HUSKY Health coverage and update your information such as your household size, income, and tax information. You have until [redacted], 2024, to renew your coverage. If you do not contact Access Health CT by the deadline, you will lose your HUSKY Health coverage on [redacted], 2024."* (Exhibit 7: AHCT It's Time to Renew Your HUSKY Health Coverage form 1305 dated [redacted])

6. On [redacted], 2024, the Appellant submitted an online change reporting application for his HUSKY Health renewal through the Health Insurance Exchange ("HIX") system. The Appellant's household consisted of six members: The Appellant, his spouse, and his four minor children. (Exhibit 2)

7. On [redacted], 2024, AHCT sent the Appellant form 1301 which stated in relevant part "*The following people will lose their HUSKY Health coverage. Their last day is: [redacted], 2024. Available data from the Federal Government indicates that you [redacted] are not a U.S. Citizen or do not have an eligible immigration status for applying for healthcare coverage through the Exchange."* (Exhibit 5: AHCT We Updated Your Health Care Application form 1301 dated [redacted].)

8. The issuance of this decision is timely under Connecticut General Statutes 17b-61(a), which requires that a decision be issued within [redacted] days of the request for an administrative hearing. The Appellant requested an administrative hearing on [redacted], 2024. Therefore, this decision is due not later than [redacted], 2024. However, the hearing record was extended ([redacted]) days to allow for the submission of information from the Appellant and the Department. Therefore, this decision is not due until [redacted], 2024. (Hearing Record)

CONCLUSIONS OF LAW

1. Connecticut General Statutes ("Conn. Gen. Stat.") section 17b-2 provides that 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.

   Conn. Gen. Stat. § 17b-260 provides 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.

   Conn. Gen. Stat. § 17b-264 provides for the extension of other public assistance provisions. All 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.

   The Department has the authority to administer the Medicaid in the State of Connecticut.

2. Title 45 of the Code of Federal Regulations ("C.F.R.") section 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.

   45 C.F.R. § 155.505(c)(1) provides that 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 appeals process in accordance with the requirements of this subpart.

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

   AHCT is the Department's designated state exchange to administer the HIX program.

   AHCT has the authority to review the Appellant's HUSKY Health Medicaid application and determine whether he meets the eligibility requirements for HUSKY Health Medicaid coverage.

3. The Afghan Allies Protection Act of 2009 Section 602(b)(8) provides for resettlement support. A citizen or national of Afghanistan who is granted special immigrant status described in section 101(a)(27) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(27)) shall be eligible for resettlement assistance, entitlement programs, and other benefits available to refugees admitted under section 207 of such Act (8 U.S.C. 1157) to the same extent, and for the same periods of time, as such refugees.

   Title 8 of the United States Code ("U.S.C.") section 1101(a)(27)(D) provides that the term "special immigrant" means (D) an immigrant who is an employee, or an honorably retired former employee, of the United States Government abroad, or of the American Institute in Taiwan, and who has performed faithful service for a total of fifteen years, or more, and his accompanying spouse and children: Provided, That the principal officer of a Foreign Service establishment (or, in the case of the American Institute in Taiwan, the Director thereof), in his discretion, shall have recommended the granting of special immigrant status to such alien in exceptional circumstances and the Secretary of State approves such recommendation and finds that it is in the national interest to grant such status.

The U.S. Citizenship and Immigration Services website provides for Afghan Arrival Categories, Codes, and SAVE Responses. SI and Non-SI Parolee Form I-766, Employment Authorization Document (EAD) Afghan SI and non-SI parolees are both paroled into the United States under section 212(d)(5) of the Immigration and Nationality Act and may have a Form I-766, Employment Authorization Document (EAD), with a C11 category and/or a CBP "PAROLED" stamp in their passport. https://www.uscis.gov/save/save-resources/information-for-save-users-afghan-arrival-categories-documentation-and-save-responses

8 U.S.C. § 1641(b)(3) provides that the term "qualified alien" means an alien who, at the time the alien applies for, receives, or attempts to receive a Federal public benefit, is (3) a refugee who is admitted to the United States under section 207 of such Act [8 U.S.C. 1157].

The Appellant is a non-citizen with Special Immigrant Parolee status and is eligible for the same benefits to the same extent and for the same periods of time available to refugees admitted under section 207 of the Immigration and Nationality Act.

4. 42 C.F.R. § 435.406(a)(2)(i) provides for Citizenship and non-citizen eligibility. 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 an non-citizen in a satisfactory immigration status.

   45 C.F.R. § 400.93 provides for the opportunity to apply for medical assistance. (a) A State must provide any individual wishing to do so an opportunity to apply for medical assistance and must determine the eligibility of each applicant. (b) In determining eligibility for medical assistance, the State agency must comply with regulations governing applications, determinations of eligibility, and furnishing Medicaid (including the opportunity for fair hearings) in the States and the District of Columbia under 42 CFR part 435, subpart J, and in Guam, Puerto Rico, and the Virgin Islands under 42 CFR part 436, subpart J, and 42 CFR part 431, subpart E. (c) Notwithstanding any other provision of law, the State must notify promptly the agency (or local affiliate) which provided for the initial resettlement of a refugee whenever the refugee applies for medical assistance. (d) In providing notice to an applicant or recipient to indicate that assistance has been authorized or that it has been denied or terminated, the State must specify the program(s) to which the notice applies, clearly distinguishing between refugee medical assistance and Medicaid or the State Children's Health Insurance Program (SCHIP). For example, if a refugee applies for assistance, is determined ineligible for Medicaid or the State Children's

Health Insurance Program (SCHIP) but eligible for refugee medical assistance, the notice must specify clearly the determinations with respect both to Medicaid or the State Children's Health Insurance Program (SCHIP) and to refugee medical assistance.

45 C.F.R. § 400.94 provides for the determination of eligibility for Medicaid. (a) The State must determine Medicaid and SCHIP eligibility under its Medicaid and SCHIP State plans for each individual member of a family unit that applies for medical assistance. (b) A State that provides Medicaid to medically needy individuals in the State under its State plan must determine a refugee applicant's eligibility for Medicaid as medically needy. (c) A State must provide medical assistance under the Medicaid and SCHIP programs to all refugees eligible under its State plans.(d) If the appropriate State agency determines that the refugee applicant is not eligible for Medicaid or SCHIP under its State plans, the State must determine the applicant's eligibility for refugee medical assistance.

45 C.F.R. § 400.100 provides for general eligibility requirements. (a) Eligibility for refugee medical assistance is limited to those refugees who (1) Are ineligible for Medicaid or SCHIP but meet the financial eligibility standards under § 400.101; (2) Meet immigration status and identification requirements in subpart D of this part or are the dependent children of, and part of the same assistance unit as, individuals who meet the requirements in subpart D, subject to the limitation in § 400.208 of this part with respect to nonrefugee children; (3) Meet eligibility requirements and conditions in this subpart; (4) Provide the name of the resettlement agency which resettled them; and (5) Are not full-time students in institutions of higher education, as defined by the Director, except where such enrollment is approved by the State, or its designee, as part of an individual employability plan for a refugee under § 400.79 of this part or a plan for an unaccompanied minor in accordance with § 400.112. (b) A refugee may be eligible for refugee medical assistance under this subpart during a period of time to be determined by the Director in accordance with § 400.211. (c) The State agency may not require that a refugee actually receive or apply for refugee cash assistance as a condition of eligibility for refugee medical assistance. (d) All recipients of refugee cash assistance who are not eligible for Medicaid or SCHIP are eligible for refugee medical assistance.

AHCT correctly evaluated the Appellant's eligibility for medical assistance.

5. 45 C.F.R. § 400.211(a) provides for the methodology to be used to determine time-eligibility of refugees. (a) The time-eligibility period for refugee cash assistance and refugee medical assistance will be determined by the Director each year, based on appropriated funds available for the fiscal year. The Director will make a determination of the eligibility period each year as soon as possible after funds are appropriated for the refugee program, and also at subsequent points during the fiscal year, only if a reduction in the eligibility period is indicated, based on updated information on refugee flows and State reports on receipt of assistance and expenditures. The method to be used to determine the RCA/RMA eligibility period

will include the following steps and will be applied to various RCA/RMA time-eligibility periods in order to determine the time-eligibility period which will provide the most number of months without incurring a shortfall in funds for the fiscal year.

45 C.F.R. § 400.211(b) provides that if, as the Director determines, the period of eligibility needs to be changed from the eligibility period in effect at the time, the Director will publish a final notice in the Federal Register, announcing the new period of eligibility for refugee cash assistance and refugee medical assistance and the effective date for implementing the new eligibility period. States will be given as much notice as available funds will allow without resulting in a further reduction in the eligibility period. At a minimum, States will be given 30 days' notice.

8 U.S.C. § 1522(e)(1) provides for cash assistance and medical assistance to refugees. (1) The Director is authorized to provide assistance, reimbursement to States, and grants to, and contracts with, public or private non-profit agencies for 100 per centum of the cash assistance and medical assistance provided to any refugee during the thirty-six month period beginning with the first month in which such refugee has entered the United States and for the identifiable and reasonable administrative costs of providing this assistance.

Federal Register Volume 87 No. 59 (March 28, 2022) p. 17312 provides that in accordance with ORR regulations, the Director of ORR is announcing the expansion of the Refugee Cash Assistance (RCA) and Refugee Medical Assistance (RMA) eligibility period from 8 months to 12 months of assistance for participants whose date of eligibility for ORR benefits is on or after October 1, 2021. Through the Refugee Act of 1980, Congress authorized cash and medical assistance up to 36 months, yet by fiscal year (FY) 1992, mainly due to insufficient appropriations, ORR had reduced the RCA and RMA eligibility periods to 8 months. For 30 years, ORR has not increased the RCA or RMA eligibility period. Extending the RCA and RMA eligibility period will lead to more effective resettlement, by providing refugee and other ORR eligible populations with additional time to become self-sufficient. DATES: The changes described in this Federal Register notice are effective as of the date of publication.

The Appellant is subject to the twelve (12) month time-eligibility period for refugee medical assistance.

AHCT correctly determined the Appellant no longer has an eligible immigration status for healthcare coverage and correctly closed the Appellant’s HUSKY Health coverage.

42 C.F.R. § 431.206 provides for informing applicants and beneficiaries. (a) The agency must issue and publicize its hearing procedures. (b) The agency must, at the time specified in paragraph (c) of this section, inform every applicant or beneficiary in writing (1) Of his or her right to a fair hearing and right to request an expedited fair hearing; (2) Of the method by which he may obtain a hearing;(3) That he may represent himself or use legal counsel, a relative, a friend, or other spokesman; and (4) Of the time frames in which the agency must take final administrative action, in accordance with § 431.244(f). (c) The agency must provide the information required in paragraph (b) of this section (1) At the time that the individual applies for Medicaid; (2) At the time the agency denies an individual's claim for eligibility, benefits or services; or denies a request for exemption from mandatory enrollment in an Alternative Benefit Plan; or takes other action, as defined at § 431.201; or whenever a hearing is otherwise required in accordance with § 431.220(a). (d) If, in accordance with § 431.10(c)(1)(ii), the agency has delegated authority to the Exchange or Exchange appeals entity to conduct the fair hearing, the agency must inform the individual in writing that (1) He or she has the right to have his or her hearing before the agency, instead of the Exchange or the Exchange appeals entity; and (2) The method by which the individual may make such election; (e) The information required under this subpart must be accessible to individuals who are limited English proficient and to individuals with disabilities, consistent with § 435.905(b) of this chapter, and may be provided in electronic format in accordance with § 435.918 of this chapter.

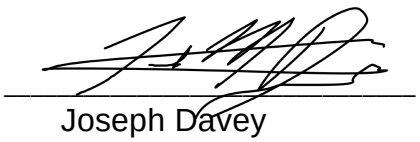
42 C.F.R. § 431.210 provides for the content of notice. A notice required under § 431.206 (c)(2), (c)(3), or (c)(4) of this subpart must contain (a) A statement of what action the agency, skilled nursing facility, or nursing facility intends to take and the effective date of such action; (b) A clear statement of the specific reasons supporting the intended action; (c) The specific regulations that support, or the change in Federal or State law that requires, the action; (d) An explanation of (1) The individual's right to request a local evidentiary hearing if one is available, or a State agency hearing; or (2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and (e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

42 C.F.R. § 431.211 provides for advance notice. The State or local agency must send a notice at least 10 days before the date of action, except as permitted under §§ 431.213 and 431.214.

On [redacted], 2024, AHCT correctly informed the Appellant of his [redacted], 2024, HUSKY Health closure via the *"We Updated Your Health Care Application"* form 1301, and correctly sent the notice more than ten (10) days before the action.

DECISION

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



Joseph Davey
Administrative Hearing Officer

Cc: Becky Brown, Health Insurance Exchange, Access Health CT
Mike Towers, Health Insurance Exchange, Access Health CT
Danielle Valente, Health Insurance Exchange, Access Health CT
Cathy Davis, AHCT Representative
ctadministrativereview@conduent.com

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.