Rhode Island Executive Office of Health and Human Services
Appeals Office, 57 Howard Ave., LP Building, 2nd floor, Cranston, RI 02920
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Date: April 17, 2015

Docket # 14-2106
Hearing Date: March 23, 2015

[redacted]

ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been decided for you. During the course of the proceeding, the following issue(s) and Agency regulation(s) were the matters before the hearing:

EXECUTICE OFFICE OF HEALTH AND HUMAN SERVICES (EOHHS)
MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)
SECTION: 0302 Medicaid Application
1306.05 Responsibilities of the Medicaid Agency

The facts of your case, the Agency regulation(s) and the complete administrative decision made in this matter follow. Your rights to judicial review of this decision are found on the last page of this decision.

Copies of this decision have been sent to the following: You (the Appellant), [redacted] (Appellant's dependent) and Sandra Cipriano the Agency Medical Assistance Supervisor.

Present at the hearing were: You (the Appellant), [redacted] (Appellant's dependent) and Sandra Cipriano the Agency Medical Assistance Supervisor.

ISSUE: Is the Appellant's dependent eligible for retro Medicaid coverage effective to September 1, 2014?

EOHHS RULES AND REGULATIONS:
Please see the attached APPENDIX for pertinent excerpts from the Rhode Island Executive Office of Health and Human Services Medicaid Code of Administrative Rules (MCAR).

APPEAL RIGHTS:
Please see attached NOTICE OF APPELLATE RIGHTS at the end of this decision.

Please see the attached APPENDIX for pertinent excerpts from the Rhode Island Executive Office of Health and Human Services Medicaid Code of Administrative Rules (MCAR).

DISCUSSION OF THE EVIDENCE:

The HealthSource RI Representatives testified:

- The agency issued a Notice to the Appellant on August 16, 2014 informing her that her Medicaid coverage would be terminating on August 31, 2014 due to the household income could not be verified and income verification period has ended. This notice also stated that the Appellant's dependent's Medicaid would terminate for the same reason but on March 31, 2015.
- The Agency issued another notice on October 4, 2014 which corrected the Appellant's issue of losing her Medicaid on August 31, 2014 as stated in the August 16, 2014 notice and was reinstating the Appellant's Medicaid eligible effective September 1, 2014. But the Appellant's dependent's Medicaid coverage of eligibility would restart October 1, 2014.
- It appears that there was a glitch in the system, the agency is already attempting to resolve this issue and that it may take another two weeks to resolve.

The Appellant testified:

- For some unknown reason, the Appellant lost her Medicaid coverage three to four times in 2014. The Appellant would call HSRI/the Agency and the problem would be fixed. This would only happen to her and not her dependent.
- In August of 2014, the issue happened again, she made a call, explained the issue and was asked if this also affected her dependent, not knowing it did since it never had, the Appellant said no, the dependent was all set.
- The Appellant's dependent attempted to use his Medicaid benefits/card in September of 2014 and was informed that he didn't have coverage; this is why an appeal was filed.
- The Appellant's dependent never received notice that he would be losing his Medicaid coverage and even in the notices that the Agency presented at Hearing, there is no notice that has been issued that gave the Appellant's dependent notice of terminating his Medicaid coverage or a closure notice.

FINDINGS OF FACT:

- The agency issued a Notice to the Appellant on August 16, 2014 informing her that her Medicaid coverage would be terminating on August 31, 2014 due to the household income could not be verified and income verification period has ended. This notice also stated that the Appellant's dependent's Medicaid would terminate for the same reason but on March 31, 2015.
- The Agency issued another notice on October 4, 2014 which corrected the Appellant's issue of losing her Medicaid on August 31, 2014 as stated in the August 16, 2014 notice and was reinstating the Appellant's Medicaid eligible

effective September 1, 2014. But the Appellant's dependent's Medicaid coverage of eligibility would restart October 1, 2014.

- It appears that there was a glitch in the system, the agency is already attempting to resolve this issue and that it may take another two weeks to resolve.
- For some unknown reason, the Appellant lost her Medicaid coverage three to four times in 2014. The Appellant would call HSRI/the Agency and the problem would be fixed. This would only happen to her and not her dependent.
- In August of 2014, the issue happened again, she made a call, explained the issue and was asked if this also affected her dependent, not knowing it did since it never had, the Appellant said no, the dependent was all set.
- The Appellant's dependent attempted to use his Medicaid benefits/card in September of 2014 and was informed that he didn't have coverage; this is why an appeal was filed.
- The Appellant's dependent never received notice that he would be losing his Medicaid coverage and even in the notices that the Agency presented at Hearing, there is no notice that has been issued that gave the Appellant's dependent notice of terminating his Medicaid coverage or a closure notice.

CONCLUSION:

The issue to be decided is whether the Appellant's dependent is eligible for retro Medicaid coverage effective to September 1, 2014?

The Agency issued a Medicaid Termination Notice to the Appellant on August 16, 2014 due to the household income could not be verified and income verification period had ended; the closure would be effective August 31, 2014. This notice also noted that the Appellant's dependent's eligibility end date was March 31, 2015 and therefore would only effect the Appellant within the next fifteen days.

The Agency was obligated to issue this notice to the Appellant because her benefits would be changing as a result of her household income was not verified. Medicaid Code of Administrative Rules § 0302, Medicaid Application states in part that:

D. Written notice is provided to each applicant stating the Medicaid agency's eligibility decision, the basis for the decision, and an applicant's right to appeal and request a hearing. In instances in which the applicant is determined to be eligible, a notice is provided indicating the length of time the applicant will remain eligible – the "*eligibility period*" -- until before a renewal of continuing eligibility is required. The period of Medicaid eligibility for IHCC group members is as follows:

(1) General eligibility period. When an individual is determined eligible for Medicaid, eligibility exists for the entire first month. Therefore, eligibility begins on the first day of the month in which the individual is determined eligible. Medicaid ends when the individual is determined to no longer meet the program's eligibility requirements and proper notification has been given or the beneficiary fails to renew eligibility as required. Medicaid benefits cease on the last day of the ten (10) day notice period when eligibility is determined to no longer exist. Individual and couple cases remain eligible for Medicaid for up to a maximum of twelve (12) months. Certifications may be for LESSER periods if a significant change occurs or is expected to occur that may affect eligibility.

Although the reason the Appellant's household income could not be verified was due to a computer "glitch" within the DHS computer system, she was properly issued a notice informing her that her "Medicaid benefits cease on the last day of the ten (10) day notice period when eligibility is determined to no longer exist"

DHS was able to issue a corrected notice on October 4, 2014 granting the Appellant retro coverage back to September 1, 2014 and therefore never lost coverage and was made whole.

§ 1306.05 Responsibilities of the Medicaid Agency

03. Notice – The Medicaid agency must provide timely notice of:
(02) Agency Action. The Medicaid agency must provide Medicaid members with a notice stating the outcome of the renewal process and explaining the basis for any agency action

Unfortunately, the issue to be decided involves the Appellant's dependent and the fact that he somehow lost his Medicaid insurance. Both the Appellant and her dependent testified that they never received any kind of notice that the dependent would be losing his Medicaid insurance in 2014. The dependent had gone to a clinic in September and was told that he did not have coverage. The August 16, 2014 notice stated that the dependent's eligibility would end March 31, 2015 and the October 4, 2014 notice stated that the recertification date is September 30, 2015. Even the Agency had difficulty trying to understand how this "glitch" happened and the best was to resolve it.

During this Hearing the Agency testified that they were presently attempting to correct this issue and "had sent it to a department to correct...it may take another two weeks to fix". The Agency did not present at Hearing either evidence or

testimony that could indicate that the Appellant and/or her dependent's action or inaction was the cause of the dependent from losing his Medicaid insurance.

In summary, the Agency issued two notices to the Appellant that affected the Appellant's eligibility. On August 16, 2014 the Agency issued a Medicaid Termination Notice due to the Appellant's household income had not be verified and that her eligibility would end on August 31, 2014. The Appellant placed some calls to correct this issue since her income had not changed. On October 4, 2014 the Agency issued another notice, an Eligibility Decision Notice, informing the Appellant that her eligibility effective date was September 1, 2014. Unfortunately, the October 4, 2014 notice indicated that the Appellant's dependent's eligibility date would be October 1, 2014 and somehow he had lost his Medicaid insurance for the month of September 2014. The dependent never received any form of a notice that would indicate that he would be losing his Medicaid insurance and the Agency did not suggest that one had ever issued. As § 1306.05 states, "The Medicaid agency must provide Medicaid members with a notice stating the outcome of the renewal process and explaining the basis for any agency action". The Agency testified that there was a glitch in the computer system and at Hearing indicated that the issue has already been sent to a department to have it fixed. The Agency anticipates that the problem will be fixed within two weeks after this scheduled Hearing.

After a careful review of the Agency's policies, as well as the evidence and testimony given, this Appeals Officer finds that the Appellant's dependent is eligible for retro Medicaid coverage effective to September 1, 2014. The Appellant's request for relief is therefore granted.

ACTION TO BE TAKEN BY THE DHS AGENCY:

THE AGENCY IS TO GRANT THE APPELLANT'S DEPENDENT RETRO MEDICAID INSURANCE COVERAGE TO SEPTEMBER 1, 2014 WITHIN TWO (2) WEEKS OF THIS DECISION BEING ISSUED.

Thomas Gracas

Appeals Officer

APPENDIX

EXECUTICE OFFICE OF HEALTH AND HUMAN SERVICES (EOHHS)
MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)

0302 Medicaid Application

D. **Period of Eligibility**
REV: June 2014
Written notice is provided to each applicant stating the Medicaid agency's eligibility decision, the basis for the decision, and an applicant's right to appeal and request a hearing. In instances in which the applicant is determined to be eligible, a notice is provided indicating the length of time the applicant will remain eligible – the "*eligibility period*" -- until before a renewal of continuing eligibility is required. The period of Medicaid eligibility for IHCC group members is as follows:

(1) General eligibility period. When an individual is determined eligible for Medicaid, eligibility exists for the entire first month. Therefore, eligibility begins on the first day of the month in which the individual is determined eligible. Medicaid ends when the individual is determined to no longer meet the program's eligibility requirements and proper notification has been given or the beneficiary fails to renew eligibility as required. Medicaid benefits cease on the last day of the ten (10) day notice period when eligibility is determined to no longer exist. Individual and couple cases remain eligible for Medicaid for up to a maximum of twelve (12) months. Certifications may be for LESSER periods if a significant change occurs or is expected to occur that may affect eligibility.

(2) Special eligibility period – Medically-needy. In cases where the *flexible test of income* policy is applied, eligibility is established on the day the excess income is absorbed (i.e., the day the health service was provided). Eligibility is for the balance of the six (6) month period. Medically-needy eligibility continues for the full six (6) months or the balance of the six (6) month period.

(3) Medicare Premium Payment Program. Individuals eligible for benefits as a Qualified Medicare Beneficiary (QMB), a Special Low Income Medicare Beneficiary (SLMB) or a Qualified Working Disabled Individual (QWDI) are certified for a 12-month period. A Qualifying Individual (QI-1 or QI-2) is certified to the end of the calendar year.

1306.05 Responsibilities of the Medicaid Agency

03. Notice – The Medicaid agency must provide timely notice of:

(01) Renewal Date. A notice of the date of the annual renewal must be sent at least thirty (30) days prior to the renewal date. The notice must provide the Medicaid member with information on the renewal process along with instructions on how to complete any actions that are conditions of renewal. A statement of the consequences for not taking necessary actions, if any, and the right to appeal and request an administrative fair hearing must also be included. As indicated in section 1306.05.04 below, the scope of the Medicaid member's direct participation in the process varies depending on whether the Medicaid agency is implementing an active versus passive approach to renewal.

(02) Agency Action. The Medicaid agency must provide Medicaid members with a notice stating the outcome of the renewal process and explaining the basis for any agency action. In instances in which continuation of eligibility depends on the Medicaid member taking action, such as providing paper documentation or reviewing information, the notice must state the nature of the action required, establish a timeline for completing the action and indicate the consequences for failure to do so, and indicate how the Medicaid beneficiary can obtain assistance from the Medicaid agency, whether through the representative of the Contact Center or the Department of Human Services (DHS) field offices. The right to appeal and request an administrative fair hearing in accordance with MCAR section 0110 must also be included.

NOTICE OF APPELLATE RIGHTS

This Final Order constitutes a final order of the Department of Human Services pursuant to RI General Laws §42-35-12. Pursuant to RI General Laws §42-35-15, a final order may be appealed to the Superior Court sitting in and for the County of Providence within thirty (30) days of the mailing date of this decision. Such appeal, if taken, must be completed by filing a petition for review in Superior Court. The filing of the complaint does not itself stay enforcement of this order. The agency may grant, or the reviewing court may order, a stay upon the appropriate terms.

This hearing decision constitutes a final order pursuant to RI General Laws §42-35-12. An appellant may seek judicial review to the extent it is available by law. 45 CFR 155.520 grants appellants who disagree with the decision of a State Exchange appeals entity, the ability to appeal to the U.S. Department of Health And Human Services (HHS) appeals entity within thirty (30) days of the mailing date of this decision. The act of filing an appeal with HHS does not prevent or delay the enforcement of this final order.

You can file an appeal with HHS at https://www.healthcare.gov/downloads/marketplace-appeal-request-form-a.pdf or by calling 1-800-318-2596.