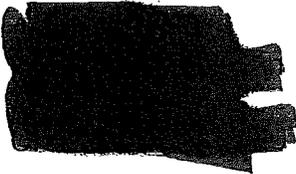


STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF HUMAN SERVICES
APPEALS OFFICE
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Docket # 15-286
Hearing Date: May 21, 2015

July 27, 2015



ADMINISTRATIVE HEARING DECISION

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

MEDICAL ASSISTANCE POLICY MANUAL SECTIONS: 0311.05, 0311.10, 0311.15, 0311.20, 0311.25.

The facts of your case, the agency policy, 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: your representative, agency representatives Gail Theriault, Ralph Racca, Mary Beth Vitullo and the Policy Unit.

Present at the hearing were: your representative, and agency representatives Gail Theriault and Ralph Racca.

ISSUE: Does the Office of Health and Human Services (OHHS) have the legal right and obligation to recover Medical Assistance paid out to the appellant as a result of a Third Party Liability (TPL) recovery? Please see the attached APPENDIX for pertinent excerpts from the Rhode Island Department of Human Services Policy Manual.

DISCUSSION OF THE EVIDENCE:

The agency representative provided the following testimony:

- The agency Third Party Liability Unit sent the Geico General Insurance Company a letter dated December 4, 2014 regarding the appellant. The letter states that the Rhode Island Executive Office of Health and Human Services holds an assignment of Collateral Assistance and asserts a lien for the appellant for an accident/injury that occurred on October 24, 2013. The Department seeks reimbursement for providing Medical Assistance totaling \$15,240.75.
- The agency representative submitted copies of the documents that were sent to the insurance company and to the appellant during the time that the settlement was pending.
- The representative submitted copies of the agency policy and RIGL that address interception of insurance payments.
- The agency representative submitted a copy of a letter dated November 27, 2013 from OHHS to Geico Insurance Company indicating at that time, in response to Geico's inquiry, there was no Medicaid lien. The letter notes that if the case remains active beyond 30 days that the insurance company should inquire about any updates regarding any Medicaid lien.
- The agency representative submitted a copy of a letter dated February 5, 2014 from OHHS to Geico Insurance Company indicating that at that time there was no Medicaid lien regarding the appellant.
- The agency representative submitted a copy of a letter dated December 4, 2014 notifying Geico Insurance Company that there was a Medical Assistance payment due on behalf of the appellant related to injuries occurring from the accident in the amount of \$15,240.75. Also attached to that letter is the notice of assignment of right as well as a spread sheet that indicates the actual expenditures made on behalf of the appellant through the Medical Assistance office.
- The agency representative submitted a copy of a letter dated December 17, 2014 from the appellant's POA inquiring about the lien and a response from the Medicaid office. The agency responded by letter dated December 30, 2014. (copy submitted).
- The agency representative stated that regarding the Medicaid reimbursement letter from Cedar Crest. The letter was actually notice to the appellant that Medicaid paid for the care she received at the facility.

The agency witness testified:

- He stated that he is an Administrator in the Office of Program Integrity and he supervises the Third Party Liability Unit. His duties as supervisor of that unit essentially requires the agency to recover from another insurer that is the primary in a medical case.
- In addition the agency recovers for Medicaid from estates and in this case from a casualty where Medicaid is obligated to recover Medicaid expenditures for a Medicaid recipient when there is a third party that may be active, in this case that is the insurance company.

- He stated that Mary Beth Vitullo works for him as a Medical Care Specialist. He stated that he is familiar with the matter under appeal. The matter was brought to his attention regarding some confusion about the facts presented at the April 13, 2015 hearing which was rescheduled for today.
- He stated that this is a typical casualty recovery case. The agency matches up with the insurance company data base to determine if a casualty claim has been recorded by the insurance company. The agency determines if there is potential for a lien and at that point a letter is sent to the insurance company stating that there is a lien with the amount or at this time there is no lien. The agency letter is good for 30 days.
- He stated that any settlement made subsequent to the agency initial letter requires the insurance company to respond to the TPL unit with settlement information.
- He stated that an agency letter dated November 27, 2013 is the first notice that went out to Geico indicating that the appellant is a Medicaid recipient and at that time there were no Medicaid claims on record with the agency. The insurance company is required to contact the TPL unit and request an update regarding the appellant before a settlement is made.
- He stated that once the initial letter is sent out by the agency whether it is to an insurance company or to an attorney representing a recipient, if a settlement is reached within 30 days of the initial letter then whatever the agency has determined at that time is the final amount.
- He stated that subsequent to the initial letter the recipient or the insurance company can request an update. The recipient or the insurance company can request an update from the agency every month or whenever an update is needed.
- He stated that it is up to the insurance company to contact the agency to get periodic updates.
- He stated that there is a one year timely filing requirement for Medicaid providers. Providers are required to submit any Medicaid claims to the Medicaid claims payment system within one year of the date of service.
- He stated that if a provider does not submit the claim in a timely manner then Medicaid can deny the claim. Providers have one year from the date of service to submit a claim to Medicaid.
- He stated that subsequent to the November 27, 2014 letter the TPL unit sent out another letter to Geico on February 5, 2014 following a request from Geico to update about the claims on this particular case. The February 5, 2014 letter stated that there were no medical claims at that time and that prior to any settlement with the appellant the insurance company needed to come back to the agency for an update.
- He stated that the agency sent a letter dated December 4, 2014 to Geico Insurance Company to notify that Medicaid had expended \$15,240.75 on behalf of the appellant as a result of her injuries from an accident that occurred on October 24, 2013.
- He stated that this is a typical time frame for this type of Medicaid lien. In this particular case the claim that was assigned a lien was for nursing home care and hospitalization. The claims from the nursing home were from October 28, 2013 through December 21, 2013. The hospitalization claim was for October 24, 2013 through October 28, 2013. The providers would have had up to one year to submit those claims to Medicaid.

- He stated that to his knowledge the \$15,240.75 lien has not been paid. He does not know if the case with the insurance company has been settled.
- He stated that he has spoken with the appellant's POA on one occasion and explained to him the entire process and policy and how it is followed. He explained the agency obligation and how the \$15,240.75 amount was determined.
- He stated that the insurance company has two options. They can send the agency a check for the \$15,240.75 or they can send the entire settlement to the recipient who is then obligated to pay the agency.
- He stated that he told the appellant's representative during a telephone conversation that the agency has a process that when an attorney is involved in a settlement of any casualty claim there is generally a fee.
- He stated that typically the fee is one-third of the settlement. The agency looks at this eventual settlement as if the attorney is in effect representing the agency. Based on the attorney representing the agency in the case for medical expenses the agency contributes towards the attorney's fees that would normally be charged to the recipient.
- He stated that when the agency allows a one-third reduction in the claim it is specifically to be applied to the attorney fees. This is based on the premise that the attorney is ultimately representing the OHHS in the litigation. The attorney fee is allowed only when the settlement involves medical expenses.
- The agency is required to seek reimbursement for medical expenses because Medicaid is a federal and state program. In this case the \$25,000.00 in the appellant's policy is specifically for medical expenses.
- He stated that if the insurance company had agreed to a settlement with the appellant in March, April or May of 2014 or any subsequent month the insurance company would have notified the agency that the settlement was pending. At that time the agency would have reported a lien of \$15,240.75 as the agency had made payment to the hospital and the nursing facility.

The appellant's representative testified:

- He stated that at the initial hearing with another agency employee the hearing officer continued the hearing because she needed duplicate copies of all documents. Today he has duplicate copies of his information.
- He stated that the 30 day period that he had to file an appeal was exceeded but the hearing office stipulated that the reason it was not received within 30 days was because the hearing forms were not available.
- He submitted a summary of what has happened to the appellant. He stated that the \$15,240.75 lien came to him with no explanation or documentation of where that amount came from.
- He submitted copies of a chronology of what has transpired since the date of the appellant's accident. The appellant was admitted to the hospital on October 24, 2013 with severe injuries. She was admitted to the Cedar Crest Rehabilitation facility on October 28, 2013.

- He received a copy of the letter to Geico from the agency stating that there was no lien on November 27, 2013. The appellant was discharged from Cedar Crest in late December 2013.
- He stated that in February 2014 after the appellant was discharged she was ready to settle with the insurance company. The insurance company made an inquiry to the agency and was told that there was no lien at that time. He stated that due to his own health issues he let the settlement drag on.
- He stated that had the appellant settled in February the insurance company would have proceeded as if there was no lien. The appellant had agreed to a settlement with the insurance company at that time.
- He stated that subsequent to February 2014 and the lack of a settlement he made certain representations to his sister. His understanding at that time was that there would be no lien on the eventual settlement. He purchased the appellant clothes and planned to send her to Florida to stay with relatives based on the understanding that there was no lien.
- He stated that later in the year when he started to feel better he contacted the insurance company and requested that the settlement be made. He stated that at that time after 14 months had passed the agency determined that \$15,240.75 was requested by the agency with no explanation.
- He stated that the agency cannot plead ignorance because he called the agency and reported that the appellant was involved in an accident. He has a document from Cedar Crest that states that the agency was notified in March 2014 that the appellant was covered by Medicaid and the facility was reimbursed.
- He stated that the fair thing to do would have been for the agency to determine when the settlement was likely to be made. He was not able to determine that a lien would occur based on the information provided from the agency.
- He stated that the agency did not provide any qualification of the no lien status. He stated that the agency allowed him to proceed with trying to help the appellant recover from the accident by purchasing her things she has never had before such as clothes and sending her to the hairdresser.
- He stated that the representations provided from the agency were misleading to him as someone who quite honestly deserved better treatment. He stated that the agency misrepresentations caused him to incur certain expenses. He had to pay expenses out of his pocket as a result of the accident because Medicaid would not replace the appellant's walker due to elapsed time policy.
- He stated that he also paid to replace the appellant's eyeglasses because the appellant was not due for new glasses under Medicaid policy. He also paid for a new chair, physical therapy, a walker, a transfer chair and a bed chair.
- He stated that Cedar Crest also billed him for \$530.00 as outstanding from the appellant's stay there.
- He stated that the agency representative that he has spoken with in the past is not here for him to question today. He stated that the agency representative told him that when there is a fixed amount of insurance coverage of \$25,000.00 liability, which is the minimum requirement under Rhode Island law, and the recipient has less than \$2000.00, in the past the agency has taken that into consideration and made adjustments.

- He stated that the agency representative told him if that was the situation the agency could make the final settlement more equitable. He stated that he has been told by the insurance company that the settlement will be for \$25,000.00 which is the maximum liability that was held by the party at fault.
- He stated that the agency representative further stated to him that in the past when there is a minimum settlement and an attorney is involved the agency has made adjustments so that the attorney gets paid for his/her services.
- He stated that if what the agency representative told him was correct the payment is limited only to attorney's getting their fee from the settlement. He stated that he has been a registered Professional Engineer for 50 years and his time is valuable.
- He stated that he has been involved with assisting the appellant since day one and if the agency allows only attorney fees it is discriminatory and he questions where the authority to allow the fees originates.
- He stated that he would like to see the policy that gives the agency the authority to make a settlement adjustment to accommodate an attorney and that the adjustment is limited to only attorneys.
- He stated that an advocate such as himself should be entitled to a similar adjustment as allowed to an attorney. He submits that the adjustment allowed by the agency is not a statutory provision or contained in the agency regulations.
- He stated that he requests the agency policy that addresses attorney fees be provided for his review. He stated that when he asked the agency Administrator if he could be allowed an adjustment similar to an attorney fee he was told that it was not possible.
- He stated that he is requesting that the lien be adjusted in an equitable manner so that the appellant receives a more equitable settlement and as adjustments have been made in the past to accommodate attorneys that he be similarly treated.
- He stated that his involvement for the past 18 months has been very substantial as the appellant is his only sister and he is her caretaker on a daily basis.
- He has a letter to submit from Geico insurance indicating that he has POA and has been representing the appellant.
- He stated that the agency failed to notify him in a timely manner that there was going to be a lien attached to the insurance settlement.

FINDINGS OF FACT:

1. The agency Third Party Liability Unit sent the Geico General Insurance Company a letter dated December 4, 2014 indicating that the agency holds an assignment of Collateral Assistance and asserts a lien for the appellant. The agency letter stated that the agency seeks reimbursement for providing Medical Assistance totaling \$15,240.75 to the appellant for her hospitalization and nursing facility costs.
2. The appellant's POA requested a hearing on this matter. He testified that the agency failed to provide him with timely notice regarding the lien amount and the agency failed to provide him with an accounting of the \$15,240.75 lien total.

3. The appellant was hospitalized on October 24, 2013. She was discharged from the hospital to a nursing facility on October 28, 2013. The appellant was discharged from the nursing facility on December 20, 2013.
4. The appellant's POA requests reimbursement similar to what the agency allows to an attorney involved in past liability settlements.
5. This record of hearing was held open through July 3, 2015 to allow both parties to review the record of evidence and submit response.

CONCLUSION:

The issue to be decided is whether the OHHS has the legal right and obligation to recover Medical Assistance paid out as a result of a TPL recovery.

The agency representatives testified that the agency Third Party Liability Unit sent the Geico General Insurance Company a letter dated December 4, 2014 regarding a lien that OHHS asserts for the appellant. The OHHS determined that the appellant was involved in an accident on October 4, 2013. The appellant was hospitalized and also admitted to a nursing facility at that time. The OHHS submits that Medical Assistance provided care for the appellant totaling \$15,240.75. The December 4, 2014 indicates that OHHS seeks reimbursement for that amount.

The agency representative submitted copies of correspondence to the Geico insurance company. A letter dated November 27, 2013 to Geico indicating that in response to Geico's inquiry there was no Medicaid lien. The agency representative submitted a copy of a letter dated February 5, 2014 to Geico insurance indicating that at that time there was no Medicaid lien. The agency representative submitted a copy of a spread sheet addressed to Geico insurance indicating the actual expenditures made on behalf of the appellant through the Medical Assistance office.

The agency Administrator from the agency Office of Program Integrity testified that he supervises the Third Party Liability Unit. His duties require the agency to recover from another insurer Medicaid expenditures for a Medicaid recipient when a third party is active, in this case from the insurance company. The agency representative stated that subsequent to the initial letter to the insurance company the company can request an update regarding a lien whenever an update is needed.

The Administrator testified that Medicaid providers such as hospitals or nursing facilities are required to submit any Medicaid claims to the Medicaid claims payment system within one year of the date of service. He testified that the time frame in this matter is typical for this type of Medicaid lien.

The Administrator testified that the agency has a process that when an attorney is involved in a settlement of any casualty claim there is generally a fee. The fee is typically one-third of the settlement. He stated that when the agency allows a one-third reduction in the claim it is specifically to be applied to the attorney fees. He stated that the agency is required to seek reimbursement for medical expenses because Medicaid is a federal and state program. In this matter the \$25,000.00 in the insurance policy is specifically for medical expenses.

The appellant's representative submitted a written summary of what has happened to the appellant since the October 2013 accident. He stated that the \$15,240.75 amount came to him without a detailed explanation of how that amount was determined. The appellant was admitted to the hospital on October 24, 2013 with severe injuries. She was subsequently admitted to Cedar Crest Rehabilitation facility on October 28, 2013. The appellant was discharged home in late December 2013. He stated that the appellant was ready to settle with the insurance company in February 2014 as the insurance company was told by the agency that there was no lien at that time. His understanding at that time was that there would be no lien and he purchased the appellant clothes and other supplies using his own funds.

The appellant's representative testified that some 14 months after the accident the agency requested \$15,240.75 without explanation. He stated that based on the information provided by the agency he was unable to determine if or when a lien would be applied to the settlement. He testified that an agency representative told him that if there is a fixed amount of \$25,000.00 liability and the recipient has less than \$2000.00 the agency has made adjustments in the past. He testified that it is his understanding that when there is a minimum settlement and an attorney is involved the agency has made adjustments to a settlement so the attorney gets paid for his/her services. He testified that he would like to see the policy that gives the agency the authority to make a settlement adjustment to accommodate an attorney. He testified that an advocate such as himself should be entitled to a similar adjustment as allowed to an attorney.

The agency legal representative responded to this record during the record held open period. The representative submits a discussion of the OHHS process that allows attorney fees regarding third party liability settlements when there is a Medical Assistance lien. The settlement to OHHS's knowledge was based upon the Geico Insurance Company and the maximum pay-out limit of \$25,000.00. There was no lawsuit filed in this case and the recipient's brother was involved as he is the recipient's Power of attorney.

Medicaid is a federal-state public assistance program that pays hospitals, nursing homes, doctors, and other health care providers for medical care provided. Rhode participates in the Medicaid program and it is administered by the OHHS. Medicaid is generally the "payer of last resort." This means that, with certain exceptions, Medicaid's responsibility for paying the cost of covered medical services for an eligible Medicaid beneficiary is secondary to that of any other "third party" who is or may be liable for paying the cost of medical care that is covered under a state Medicaid program.

The representative submits that Medicaid's third party liability ("TPL") rules are set forth in several provisions of the Federal Medicaid statute. One of the provisions requires state Medicaid programs to ascertain the legal liability of third parties to pay for medical care provided under their Medicaid plans and to seek reimbursement from third parties with respect to such care and services if their legal liability is found to exist after medical assistance has been made available on behalf of an eligible Medicaid beneficiary and

the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery. (42 U.S.C 12396(a)(25)(A), (B).

The agency representative submitted a copy of a letter dated December 30, 2014 that is addressed to the appellant's POA. The letter states, "I have received your letter in regard to the appellant's lien notification. At the time the letters were sent to the appellant stating that Medicaid did not hold a lien, the providers had not yet billed Medicaid for services rendered. The providers have up to one year from the date of service to bill Medicaid. That is the reason we ask the insurance companies and attorney's to request an updated lien notice before settling their case. Claims are paid and reimbursements are made daily."

The agency representative submits that federal law requires a state's Medicaid program to require a Medicaid beneficiary, as a condition of Medicaid eligibility, "to assign to the State the beneficiary's rights to payment for medical care from any third party and to cooperate with the State in identifying, and providing information to assist the state in pursuing, any third party who may be liable to pay for care and services provided under the state Medicaid plan. Pursuant to Federal laws and regulations, Rhode Island has enacted R.I. Gen. Laws 27-57.1 et al, R.I. Gen. Laws 40-6-9 and OHHS Regulations 0311.05-0311.20 which give OHHS the right and obligation to recover Medicaid paid out as a result of a third party liability recovery. In the case at issue Medicaid paid a total of \$15,240.75 on behalf of the appellant for medical bills related to her third party liability recovery. There was no litigation in this matter. There was a maximum coverage pay-out of \$25,000.00 by the insurance company.

The agency representative submits that OHHS is required to follow the dictates of United State Investment and Development Corp., v. RI DHS and pay a pro rata share of the attorney's fees and costs from its lien. In this case OHHS was never made a party to the negotiations or settlement and therefore was not given an opportunity to protect its interests in the claims. OHHS should not have to compromise its claim under 40-6-9 and is not responsible for any costs of this settlement. The appellant's representative is not an attorney and there are no legal fees in this matter. All cases that OHHS had been involved in when its TPL claim has been compromised and payments towards a percentage of the legal fees has been paid, involved a civil lawsuit being filed and an attorney engaged for their professional services.

The agency representative submits that there is no formal OHHS policy regarding TPL Casualty reduction for attorney's fees and costs. Every case is reviewed on a case-by-case basis in either the TPL unit or the OHHS legal office and a formal request must be made. All requests for lien reductions need to be made in writing, with proof of the total settlement amount, total costs, any other lien holders/lien amounts, attorney's fee structure and certification of the settlement check. In the instant case, there are no attorney fees since no lawyer was engaged and any costs incurred by the appellant's representative on behalf of the appellant do not meet the requirements of a TPL reduction.(copies of cited references submitted).

The agency representative submitted her review of the documents submitted by the appellant's representative in support of his argument that the OHHS should pay a share of the reimbursement of medical costs associated with the Medical assistance paid out

to the appellant for the medical care. The appellant received \$25,000.00 from Geico Insurance Company related to her accident in 2013.

The agency representative submits that her review determined that the expenses submitted by the appellant's representative include a number of incidental expenses that are totally unrelated to the accident and the third party insurance payment. All of the expenses listed in Category I were submitted to Medicare as the primary insurer and were paid. The appellant was responsible for the patient share. These are unrelated to any Medical Assistance bills paid on her behalf. The payment made to Cedar Crest was paid by Medical assistance and the \$530.00 paid by the appellant was her applied income. Medical Assistance does not pay for telephone charges made in the nursing home. Again this is irrelevant to the issue being considered in this hearing. Expenditures made to purchase equipment (walker and chair) maybe covered by Medicare.

All of the expenditures listed in Category No. II are all irrelevant to the issue being determined. The exorbitant amount of \$12,500.00 spent on food (Newport Creamery), hair, cloths and transportation all would have been expected whether the appellant was injured or not. The payments allowed on third party liability suits are not for those types of expenditures. They are for expenditures related to costs of litigation.

The expenditures listed in Category No. III are not related to any litigation associated with the \$25,000.00 limit paid out by Geico Insurance Company on the policy limit involved with the accident. Although it does not pertain to this matter because there was no attorney and no litigation, according to United State Investment and Development Corp., v. RI DHS 606 A. 2d, the appellant has the burden of showing that the assessment of a pro-rated share is equitable and that recovery costs are justified. In this case OHHS was never made a party to the "negotiations" therefore was not given an opportunity to protect its interests in the claims. There is also no justification or itemization for the \$8,333.00 claimed by the appellant's representative in his role as POA for the appellant. He is requesting one-third of the \$25,000.00 insurance payment. OHHS does not give thirty-three percent (33%) to lawyers in cases where a lawsuit has been initiated and even litigated. The highest is twenty-five percent (25%) plus litigation costs (i.e. court filing fees).

The agency representative submits that per the agency position stated in the original memorandum, OHHS should not have to compromise its claim under 40-6-9 and is not responsible for any costs claimed by the appellant's POA from the insurance settlement. The appellant's representative is not an attorney and there are no legal fees involved in this matter. The appellant should reimburse her brother for any expenses he incurred. It is no different than when a court appointed guardian seeks reimbursement for costs and time spent on their respective ward. All TPL cases that OHHS has been involved in when a claim has been compromised and payment towards a percentage of the legal fees has been paid, involved a civil lawsuit being filed and an attorney engaged for their professional legal services.

The appellant's representative submitted additional information to this record during the held open period. He submitted a letter with attached exhibits dated June 1, 2015 and a letter dated June 30, 2015 in response to the agency review of his testimony and exhibits.

The June 1, 2015 letter states, "This letter is in response to your letter dated May 21, 2015 addressed to my sister for whom I have POA. I trust I have enclosed the documents you requested which are needed to adjudicate this matter in an equitable manner taking precedents into consideration. Please note that there are three categories of expenses depicted on the enclosed sheet dated June 1, 2015 and numbered Sheet 1 of 1: I. Out of pocket accident related expenses not covered by Medicare or Medicaid with receipts. II. Expenditures I incurred believing the Department of Human Services had no lien in this matter. The first lien notification was issued 14 months after the accident even though the Department of Human Services was aware of the accident soon after it happened and had twice notified all parties to the contrary. III. The standard fee for my substantial effort attending to this matter with various agencies and overseeing all related matters as my sister is physically and mentally limited".

The June 30, 2015 letter states, "This is in reply to your letter dated June 22, 2015 regarding the above referenced docket number. The memorandum dated June 16, 2015 prepared by Gail Theriault, Administrative and Legal Support Services Administrator submitted with attachments A and B have been carefully reviewed. The laws and case laws presented with her memorandum are not the only considerations in this case. Rather, the authority given to the DHS under the applicable statutes has been misused and has not been administered fairly in this case. There is nothing in any of the documents submitted which justify in a logical common-sense manner the actions and inactions DHS has taken to date. Was it the intent of the lawmakers to leave an 85 year old woman who had a near death, life altering accident with little or no compensation? There is no law or case law to justify such a position. Further, the misleading and untimely actions of the DHS have not only caused a delay in resolving this matter but have resulted in expenditures made known at the hearing. The following primary facts are again offered for your consideration: 1. My sister's accident took place in October 2013. It was made known to the DHS soon thereafter by me and perhaps others. Payments were made to Cedar Crest Rehabilitation facility by the DHS on my sister's behalf in March 2014. A letter I solicited from the rehabilitation facility in 2015 (Exhibit 2) confirm payments were made in March 2014 further refuting ignorance of this matter on the part of DHS. 2. In December 2014, fourteen (14) months after the accident, Geico and I were notified by DHS for the first time that a \$15,240.75 DHS lien had been placed upon the pending settlement. In the interim months prior to the lien notification, DHS twice notified Geico and me in writing there was no DHS lien in this matter. There was never the slightest suggestion or indication by anyone at any time that a lien would or could be forthcoming. 3. These misleading no-lien notifications caused me to make certain expenditures on my sister's behalf, which were documented at the hearing. She deserved to be treated for enduring the pain and suffering caused by the accident. The actions taken were based on the pending no DHS lien settlement. Further her physical and emotional rehabilitation was aided by my promise to send her to Florida for an extended vacation living there with relatives. This promise was not fulfilled. In summation, this 85 year old person's life has been impaired by the October 2013 accident through no fault of her own. To leave her with little or no compensation would be a miscarriage of justice. The law should be considered with the totality of the circumstances. The misleading actions of DHS should be given particular weight.

The appellant's representative submits please see the last sheet (unnumbered) first paragraph of Ms. Theriault's previously referenced memorandum dated June 18, 2015. She states: "There is no formal policy regarding TPL Casualty reduction for attorney's fee and costs. Every case is reviewed on a case-by-case basis in either the TPL unit or the OHHS legal office and a formal request must be made." This statement is revealing. It is consistent with what Mary Beth Vitullo, a DHS staff member told me. It is the DHS present position that I should not be compensated because I am not an attorney. There is a logical reason why I chose to represent my sister in this matter. The maximum amount available was \$25,000.00. Therefore it did not make economic sense to retain the services of an attorney. Where is the legal authority that stipulates an advocate for a Medicaid recipient involved in an accident must be a lawyer in order to qualify for compensation? The effort I've expended over the past 18 months in an attempt to resolve this matter has been most substantial because it affects my sister. If the DHS decision excludes compensation for me, my sister's advocate, without a legal basis, then its position is discriminatory. I was informed by the same Mary Beth Vitullo of DHS there are precedents in cases such as my sister's where a Medicaid lien has been reduced so as to treat both the Medicaid recipient and the advocate lawyer fairly. Unfortunately, Ms. Vitullo who has been my primary DHS contact person was unexpectedly absent at the hearing. In hindsight, perhaps I should have subpoenaed her or requested a hearing postponement. I respectfully request that you eliminate or substantially reduce the pending DHS lien of \$15,240.75 so that the final resolution is equitable.

Based on review of the testimony, exhibits, and pertinent policy I have identified three issues that should be addressed by this decision. The first issue is whether the agency has the legal authority to recover Medical Assistance paid out to the appellant as a result of a TPL recovery.

Agency policy 0311.05 states,

In accordance with state law and applicable administrative rules, when applying for Medicaid, an applicant automatically assigns his/her rights to the Executive Office of Health and Human Services, the RI Medicaid state agency, any third party payments from insurers. Nothing in these sections shall limit the Executive Office of Health and Human services from recovery of any other monies allowed, to the extent of the distribution, in accordance with all state and federal laws.

The policy clearly states that OHHS, in compliance with state law has the legal authority to seek TPL recovery for payment of medical bills associated with those incurred by a recipient. The record also contains copies of State and Federal rules that clearly allow recovery of Medicaid payment from third parties when a provider has billed Medicaid for payment of medical bills.

The second issue is the matter of the notice of lien that the appellant's representative argues were not timely and provided him with misinformation about the action that the agency intended to take.

The record contains copies of three separate letters that were sent to the insurance company from the agency in this matter. Letters dated November 27, 2013 and February 5, 2014 state that the OHHS and Medicaid does not **currently** hold a lien for the appellant. The letters instruct the insurance company that if the case remains active for more than 30 days a new request should be made prior to settlement. The letter instructs the insurance company to visit the agency web site to request an update before all settlements. Agency policy 0311.10 addresses the time frames and the criteria that insurers follow when a claimant has received Medicaid services.

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"Every domestic insurer or insurance company authorized to issue policies of liability insurance and any worker's compensation insurer, shall review information provided by the Executive Office of Health and Human Services, pursuant to RIGL chapter 27-57.1, indicating whether or not the claimant has received Medicaid funded services as a result of an accident or loss which is the basis of the claim. Said review shall occur within thirty (30) days prior to making any payment equal to or in excess of five hundred dollars (\$500.00) to any claimant who is a resident of this state, for personal injury or workers' compensation benefits under a contract of insurance.

The Executive Office of Health and Human Services shall electronically furnish these insurers and insurance companies with a database data match option report of names of individuals with last known addresses, as of the date of the report, who have received Medicaid in excess of five hundred dollars (\$500).

To facilitate the efficient and prompt reporting of those Medicaid beneficiaries in one centralized location, the duty and responsibility of the insurance companies doing business is as follows:

- o Utilize one centralized database, to which the Executive Office of Health and Human Services shall report and administer.
- o Any insurer receiving information identifying a Medicaid beneficiary shall maintain the confidentiality of that information to the full extent required under federal and state law. Minimal data elements, including, but not limited to, the date of injury and other necessary identifying information, shall be shared with an agency contracted by the Executive Office of Health and Human Services which maintains a centralized database of insurance claims.

The contracted centralized database is required to keep confidential: any personal and personnel information; records sufficient to identify a person applying for or receiving Medicaid; preliminary drafts, notes, impressions, memoranda,

working papers, and work products; as well as any other records, reports, opinions, information, and statements deemed confidential pursuant to state or federal law or regulation, or rule of court. Any such confidential data shall not be disclosed to the insurer.

Matched results indicating that a beneficiary is a claimant of an insurer are returned to the Executive Office of Health and Human Services through its contracted agency. Proper quality assurance shall be performed by the contracted agency to insure the claim is open. The contracted agency may also collect additional information from the insurer including but not limited to contact information.

If the insurer determines from the information provided by the Executive Office of Health and Human Services, pursuant to RIGL 27-57.1-4, that the claimant or payee has received Medicaid funded services, as a result of an accident or loss which is the basis of the claim, the insurer shall, except to the extent that payments are subject to liens or interests (i.e. health care providers, attorney fees, holders of security interests, or the assignment of rights under RIGL 40-6-9 and 40-6-10), withhold from payment the amount to the extent of the distribution for Medicaid as a result of an accident or loss, dating back to the date of the incident. The insurer shall pay such amount to the Executive Office of Health and Human Service and shall pay the balance to the claimant or other entitled person.

The appellant's representative argues that due to a lack of timely notice from the agency he proceeded in providing care for his sister with the understanding that no lien would be attached to the eventual settlement. He testified and submitted documentation of out of pocket costs associated with his sister's care that he incurred while waiting for the settlement. The above cited policy instructs the insurer to withhold from settlement the amount to the extent of the distribution for Medicaid as a result of an accident or loss dating back to the date of the incident. The policy does not specify a time frame in which the insurer must provide the Medicaid portion of the settlement to the agency.

Agency policy does provide a one year time frame from the date of service during which a provider can submit a claim to Medicaid. Medicaid can deny a provider claim if the claim is received by the agency more than one year from the date of service. The notices sent to the insurer and copied to the appellant's representative instructs the insurer that a new request for an updated document must be made to the agency prior to all settlements. Although the two letters state that there was currently no lien the letters allows that further inquiry is required from the insurer before any future settlement is made.

It is noted that the record contains a sufficiently detailed accounting of the cost of care provided from the hospital and from the nursing facility that the providers have billed to Medicaid in the amount of \$15, 240.75.

The appellant's representative contends that the agency was aware of the outstanding bills for more than one year but failed to resolve the payment. The agency may have been aware of the Medicaid being provided to the providers. However the agency had no control over the timing of the submission of the Medicaid claims from the providers. In this matter the issue of timeliness that is cited by the appellant's representative was in effect not controlled by the agency but by the providers for at least a 12 month period. The timeliness and notice issue is therefore a moot point as the agency complied with its policy to pursue the lien as necessary.

The third issue that is considered is the contention presented by the appellant's representative that he is entitled to some portion from the settlement between the agency and the insurer. The appellant's representative argues that just as an attorney is compensated for the time and effort spent on litigation he should also be allowed compensation for the time and effort he spent in securing the settlement for the appellant. He requests that he also be compensated for the expenses he incurred for her ongoing care. The representative submitted documentation of the expenses he incurred for medical costs, food, shelter, and the clothing needs of the appellant while he awaited the settlement from the insurer.

Agency policy requires that all TPL Casualty Reduction Requests be made in writing by a form specific to such requests. The form requires the following information: Attorney name and address, total insurance settlement amount, attorney's fees, **non-medicaid expenses**, Medicaid lien amount, non-Medicaid medical details, and non-medical expenses. In this matter there are no attorney fees as no lawyer was involved.

The costs incurred by the appellant's representative were itemized in his letter dated June 1, 2015. He submitted "out of pocket accident related expenses not covered by Medicaid or Medicare totaling \$1246.91. He submitted a list of expenses incurred resulting from 14 months of "no lien" status per DHS notifications of \$12,550.00. He itemized POA fee totaling (1/3 of insurers \$25,000.00=\$8333.00) for a total compensation/reimbursement requested of \$22,129.91.

The "out of pocket expenses accident related medical expenses not covered by Medicare or Medicaid" submitted by the appellant's representative included the \$530.00 payment made to Cedar Crest. The payment was the appellant's "applied income" due for the month of November 2014. The payment is due directly from the appellant's monthly income and is not a reimbursable medical expense.

Based on review of the evidence and testimony submitted the appellant is allowed \$716.91 from the TPL insurance settlement of \$15,240.75.

The Executive Office of Health and Human Services shall electronically furnish these insurers and insurance companies with a database data match option report of names of individuals with last known addresses, as of the date of the report, who have received Medicaid in excess of five hundred dollars (\$500).

To facilitate the efficient and prompt reporting of those Medicaid beneficiaries in one centralized location, the duty and responsibility of the insurance companies doing business is as follows:

- o Utilize one centralized database, to which the Executive Office of Health and Human Services shall report and administer.
- o Any insurer receiving information identifying a Medicaid beneficiary shall maintain the confidentiality of that information to the full extent required under federal and state law. Minimal data elements, including, but not limited to, the date of injury and other necessary identifying information, shall be shared with an agency contracted by the Executive Office of Health and Human Services which maintains a centralized database of insurance claims.

The contracted centralized database is required to keep confidential: any personal and personnel information; records sufficient to identify a person applying for or receiving Medicaid; preliminary drafts, notes, impressions, memoranda, working papers, and work products; as well as any other records, reports, opinions, information, and statements deemed confidential pursuant to state or federal law or regulation, or rule of court. Any such confidential data shall not be disclosed to the insurer.

Matched results indicating that a beneficiary is a claimant of an insurer are returned to the Executive Office of Health and Human Services through its contracted agency. Proper quality assurance shall be performed by the contracted agency to insure the claim is open. The contracted agency may also collect additional information from the insurer including but not limited to contact information.

If the insurer determines from the information provided by the Executive Office of Health and Human Services, pursuant to RIGL 27-57.1-4, that the claimant or payee has received Medicaid funded services, as a result of an accident or loss which is the

basis of the claim, the insurer shall, except to the extent that payments are subject to liens or interests (i.e. health care providers, attorney fees, holders of security interests, or the assignment of rights under RIGL 40-6-9 and 40-6-10), withhold from payment the amount to the extent of the distribution for Medicaid as a result of an accident or loss, dating back to the date of the incident. The insurer shall pay such amount to the Executive Office of Health and Human Services and shall pay the balance to the claimant or other entitled person. Workers' compensation claimants who receive Medicaid, provided in accordance with chapter 40-8, shall be subject to the provisions of RIGL 27-57.1. The workers' compensation reimbursement payments made to the Executive Office of Health and Human Services in accordance shall be limited to that set forth in chapter 28-33 and section 40-6-10.

Notice 0311.15
REV: 09/2012

The Executive Office of Health and Human Services shall provide written notice to the insurer, claimant and his/her attorney, if any, which shall include the date, name, social security number, case number, total amount of the payment proposed to be withheld to reimburse the state for Medicaid funded services and a list of the items and services, including dates of service for which reimbursement is sought. The notice shall explain the right to request a hearing pursuant to section 0311.20.

Request for Hearing 0311.20 1
REV: 09/2012

Any payments made by an insurer pursuant to this chapter, shall be made to the Executive Office of Health and Human Services, unless there is a request for an administrative hearing by the claimant. Any claimant aggrieved by any action taken under these procedures may, within thirty (30) days of the date of the notice to the claimant, request an administrative hearing from the Executive Office of Health and Human Services. If there is an administrative hearing, the insurer must remit payment within ten (10) business days of and in accordance with the hearing decision.

Payment by Insurer 0311.25
REV: 09/2012

The insurer shall make any payments required, pursuant to this chapter, to the Executive Office of Health and Human Services, thirty (30) days after the date of notification to the claimant or his/her attorney. Provided, however, that if the claimant has

requested a hearing, payment shall not be made until ten (10) days after the hearing decision and in accordance with the hearing decision.

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.