STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF HUMAN SERVICES
APPEALS OFFICE
600 New London Avenue
Cranston, Rhode Island 02920
(401) 462-2132/Fax# (401) 462-1678
TDD# (401) 462-3363

Docket # 15-766
Hearing Date: May 12, 2015

June 25, 2015

ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been decided against you. 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: 0308.05, 0318.05, 0318.10.

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: you, agency representative: Gail Scudieri and the Policy Unit.

Present at the hearing were: you, and agency representative Gail Scudieri.

ISSUE: Should the appellant's Medical Assistance coverage through United Health start effective January 1, 2015? 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 sent the appellant a notice dated January 8, 2015 informing her that her Medical Assistance became effective for her household effective January 1, 2015.
- The agency representative stated that the appellant should re-submit the bills that were incurred between January 1, 2015 and January 8, 2015. The appellant's United Health Plan coverage became effective January 9, 2015.
- The representative stated that the appellant's provider should re-submit the bills and if the provider does not accept Medicaid fee for service she will need to pay all co-pays.

The appellant testified:

- The appellant stated that the reason she is appealing is because she has bills from her child's doctor that are unpaid. She applied for medical coverage back in October 2014 but she did not get medical cards until November.
- She received a United Health card for herself only for December 1, 2014.She called HSRI, DHS, and United Health multiple times to try and rectify the problem. Everyone she contacted blamed someone else and did not help her. She even went to the HSRI office which was a waste of time.
- She stated that the last time she contacted HSRI she was told by an employee that she also did not understand why only she received a United Health care card and other family members did not.
- She stated that her entire family had coverage through Medicaid with an HMO until the end of November 2014 and everyone was covered.
- She stated that she was assured that her United Health care would start on January 1, 2015 and she could go ahead and make appointments. She did make an appointment for January 6, 2015 with Atwood Pediatrics. She is now receiving a $300.00 bill from Atwood for that appointment.
- She does not believe she should be responsible for this bill when she received a United Health care card but the rest of her family did not until January 9, 2015.

FINDINGS OF FACT:

1. The agency sent the appellant a notice dated January 8, 2015 notifying her that her household eligibility for Medical Assistance would begin January 1, 2015.
2. The appellant submitted an outstanding bill from her provider from January 6, 2015 that was not covered by either Medical Assistance or United Health care.
3. The agency reviewed the appellant's eligibility record and advised that the appellant re-submit the bill to her provider and if the provider does not accept Medicaid she will need to pay all co-pays.
4. The appellant's eligibility with United Health care started effective January 9, 2015.

CONCLUSION:

The issue to be decided is whether the appellant's eligibility for United Health care should start effective January 1, 2015.

Review of the agency record determines that the agency sent the appellant notice dated November 16, 2014 notifying her that she was eligible for Medicaid effective January 1, 2015. The notice states that the remaining members of the appellant's household were not eligible for Medicaid at that time because the household failed to provide requested relationship information.

The agency notified the appellant by notice dated January 8, 2015 that her household's eligibility for Medical Assistance would begin effective January 1, 2015. The agency determined the appellant's household's Medical Assistance effective January 1, 2015 following receipt of the requested renewal application information.

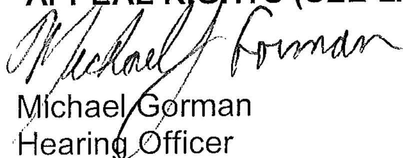
The appellant has submitted an unpaid bill that she incurred during a lapse in her Medical Assistance/HMO coverage that occurred during the first week of January 2015.

Review of the agency testimony determines that the appellant's case was re-opened by the agency with a January 1, 2015 Medical Assistance effective date. The agency testimony is that when a case closes there can be a lapse in eligibility of 1 to2 weeks before the HMO reopens the eligibility.
In this matter the appellant's HMO did not reopen the appellant's eligibility until January 9, 2015. The appellant's provider does not accept Medical Assistance and as a result the appellant has been billed for services by her provider incurred on January 6, 2015.

Review of the agency notice dated January 8, 2015 determines that the notice states that the appellant's family is eligible to enroll with United Health care. The notice states that as of January 8, 2015 the appellant's household members are eligible to use fee-for-service Medicaid to pay for some benefits not covered by the Medicaid health plan. To access these services, you can use your White Medicaid Anchor Card, or present the notice to your provider when you go to your appointment.
The January 8, 2015 notice also states that, "We have determined that the members of the appellant's household are eligible for Medicaid, but they have not enrolled in a plan. Please visit the Exchange website or call the Exchange contact center to enroll in a plan."

After careful review of the agency policy, the evidence and testimony submitted, it must be found that the agency complied with its application policy. The agency recertified the appellant's Medical Assistance eligibility effective January 1, 2015.
This hearing officer has no jurisdiction with the HMO and the date of the appellant's eligibility reinstatement determined by United Health care. The agency January 8, 2015 notice provided instruction on how to enroll in the United Health care plan and that until enrolled the appellant's household would remain eligible for Medicaid. I find the agency decision to determine the appellant's household eligible for Medicaid effective January 1, 2015 to be correct. The appellant's request for relief is denied.

APPEAL RIGHTS (SEE LAST PAGE)



Michael Gorman
Hearing Officer

APPENDIX

APPLICANT REQUIRED TO COOPERATE 0308.05
REV: 04/2001

As a condition of eligibility, the MA applicant must meet certain cooperation requirements. These requirements include:

- o Providing the information needed for an eligibility determination;
- o Assignment of rights to medical support or other third party payments for medical care to the Department;
- o Cooperating in establishing paternity and obtaining support (an exception exists for pregnant women with no other children, pregnant women are not required to cooperate with Child Support Enforcement until the birth of the child);

APPLICANT REQUIRED TO COOPERATE 0308.05

- o Cooperating in identifying and providing third party liability information;
- o Making resources available and utilizing resources;
- o Cooperating in Quality Control procedures;
- o Enrollment in cost effective employer-sponsored health insurance through the RIte Share Premium Assistance Program (Section 0349).

REDETERMINATION OF MA ELIGIBILITY 0318.05
REV: 05/1999

The redetermination of MA eligibility is based on a new application (DHS-2 or MARC-1) and supporting documents, as needed, from which

a determination is made that the recipient continues to meet all eligibility requirements.

A redetermination results in a recertification at the existing scope of services, recertification for a reduced scope of services or case closure. Redetermination precedes a case closure. A case is not closed without a positive finding of ineligibility.

For Categorically Needy and Medically Needy INDIVIDUALS and FAMILIES, a full redetermination is completed every twelve (12) months. In addition, eligibility must be redetermined whenever a change in circumstances occurs, or is expected to occur that may affect eligibility.

REDETERMINATION OF MA ELIGIBILITY 0318.05

REDETERMINATION PROCESS 0318.10 1
REV: 12/2001

Two months prior to the end of a certification period, InRHODES identifies cases due for redetermination and sends to the Management Information Systems (MIS) Unit at the DHS Central Office a list of the cases and a name and address label for each case.

The MIS Unit sends the cards, labels and list of cases due for redetermination to the appropriate district office from which redetermination packets are mailed. The list provided to the district office identifies cases as family or adult and also indicates whether the case was previously certified using the DHS-2 or MARC-1 application form.

The redetermination packet consists of the following materials, (plus other forms, and documents as they relate to the individual situation; e.g., the MA-1 Supplement when a spenddown is

indicated).

INDIVIDUALS/COUPLES	FAMILIES
DHS-2 Statement of Need	DHS-2 Statement of Need OR, as appropriate, MARC-1 Mail-In Application
Transportation Information	EPSDT Information

Pre-addressed return envelope Pre-addressed return envelope

REDETERMINATION PROCESS

0318.10 3

When the application form is returned within the required time period (prior to expiration of the certification period), the eligibility worker compares the information on the new application to the InRHODES record, entering changes once necessary verification has been provided. If the information is the same and the client remains eligible, the recipient's next redetermination date is advanced up to twelve months, as appropriate. If new information results in ineligibility or a change in the level of coverage, the worker must approve the results.

If the application is not received by the 20th of the month or ten days prior to the end of the certification period, the worker enters a non-cooperation code on the InRHODES STAT/STAT panel causing a TEN-DAY NOTICE of discontinuance to be sent.

The case closes at the end of the old certification period if the recipient has not responded by the end of the 10-day notice period.

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.