

**STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS  
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES  
APPEALS OFFICE - LP Bldg.  
57 Howard Avenue  
Cranston, RI 02920  
(401) 462-2132 / Fax # (401) 462-0458  
TDD # (401) 462-3363**

Date: September 29, 2014

Docket #14-1070  
Hearing Date: September 2, 2014

**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:

**THE DHS POLICY MANUAL: MEDICAL ASSISTANCE  
SECTION 0348.40.05 Premium Share Requirements  
SECTION 0348.40.05.05 Non-Payments or Premiums  
SECTION 0318 MEDICAL ASSISTANCE REDETERMINATION**

The facts of your case, the Agency policy, and the complete administrative decision 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), and Agency representatives: Michael Richardson, and Denise Tatro.

Present at the hearing were: You, your wife, and Agency representative Michael Richardson.

**ISSUE: Is appellant required to pay, a past due Medical Assistance (MA) bill of \$184.00 for the months of November and December 2012?**

**DHS POLICIES:** Please see the attached APPENDIX for pertinent excerpts from the Rhode Island Department of Human Services Policy Manual.

**APPEAL RIGHTS:**

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

**DISCUSSION OF THE EVIDENCE:**

**The Agency representative testified:**

- The appellant did forward a hearing request because he didn't feel responsible for the bill.
- The bill goes back to November/December of 2012.
- The last case log (CLOG) entry in the system is dated September 28, 2012, at which time the Medical Assistance (MA) recertification was completed. The medical was re-approved for a one year period.
- There are is no further requests or further information in the system that identified that the appellant had notified the Agency that they had moved out of state, and so the Agency went forward with the approval.
- A computer generated notice dated December 20, 2012 informed the appellant that his case was closing due to nonpayment of the premium.
- The Agency recently advised the appellant to file for a hearing even though two years had gone by.
- This was a Rite Care case where only the children were eligible based upon income.
- The Agency's understanding is that everyone gets billed on a monthly basis prior to the month due, but I'm not sure.

- An issue is that if the notice went to the Woonsocket address they might never have gotten the notice because they moved, and DHS mail does not get forwarded.
- It is unclear if the Rite Share bills get forwarded.
- The Agency is unable to get any copies of any old bills.

**The appellant and his wife testified:**

- The fact of the matter is that we moved November 1, 2012, and we have proof of that.
- That is the only proof we have.
- We feel that we did make a phone call, when we found that we were going to move out of state-but we don't have any proof.
- She (his wife) is very on the ball, when it comes to these things.
- We are not sure if it was prior to November 1, 2012 or on the actual moving day that we called, but most likely sometime in November.
- She can't remember if she spoke with anyone, or left a message. Normally, she does call.
- She knew they were moving out of state to get the children different health insurance, so it didn't make sense to use the RI medical assistance when they were not going to be living in RI.
- We weren't aware that as Massachusetts residents that we could have had continued coverage in RI, as we did not know our insurance had not been cancelled.
- She does not think she ever sent any letter or correspondence for closure.
- The months of November and December 2012 were billed, but we moved to MA on November 1, 2012.
- We have no copies of any Rite Care bills, and we do not remember when the November bill came.

- There was a period of time where mail got forwarded to our new address, and we do not know if we ever received the November bill.
- We don't think we tried any other attempts to contact the Agency.
- With regards to any follow up with DHS, it was out of sight, out of mind, and we were happy to be leaving RI.

#### **FINDINGS OF FACT:**

- A Medical Assistance recertification was completed on September 28, 2012, approving the appellant's children for continued medical insurance for one year.
- The appellant and his family moved to Massachusetts on November 1, 2012.
- A denial notice dated December 20, 2012 informed the appellant that her Medical Assistance (MA) would end on December 31, 2012 due to nonpayment of the family premium of \$184.00 for the months of November and December 2012.
- The December denial notice was sent to the Woonsocket, RI address of record.

#### **CONCLUSION:**

The issue to be decided is whether the appellant is required to pay a past due Medical Assistance (MA) family premium bill of \$184.00.

Per MA policy, some MA Rite Care recipients must pay a share of their premiums in order to maintain coverage. This premium is determined by coverage groups and countable family income. Additionally, a full monthly premium is due if the family received MA coverage for any portion of a coverage month.

There is no dispute that the family completed an MA recertification on September 28, 2012. There is also no dispute that the appellant's family received MA benefits prior to the family's move to Massachusetts on November 1, 2012. The Agency is in agreement that the family would not have received their December 2012 denial notice as they had already moved prior to the notification which was sent to their RI address of record. They further testified that the Agency does not forward mail. The Agency contends that

the appellant moved on November 1, 2012, but at no time changed their address, as evidenced by the case logs, and the subsequent notices sent to the same address. This resulted in continued MA coverage, and a bill owed for the months of November and December 2012. The Agency did not know whether the Rite Care bill for the two months had been sent to the old address, or forwarded to the new address; and, they were unsure of when in the billing cycle, a bill is generated for the Rite Care premiums.

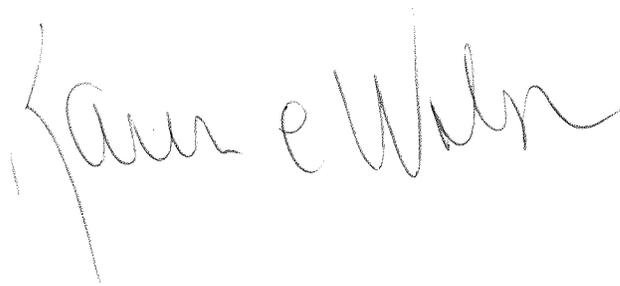
The appellant argues that his wife is always on top of things, and that she would have called the Agency to notify them of the family's move. He is not sure if this happened prior to the day of the move on November 1, 2012, or sometime later in November. His wife testified that she does not remember if she had spoken with someone or left a message, but she is fairly certain she did call. The appellant further testified that a copy of his lease clearly identified that the family had moved on November 1<sup>st</sup>, and the family should not be held responsible for insurance from RI where they no longer lived, and which they did not use.

Further examination of the evidence submitted indicates that the appellant completed the lease for his new apartment on August 17, 2012. Thus, in August he was aware that he would be moving to his Massachusetts address on November 1, 2012. In September the appellant completed his MA recertification which did not reflect this upcoming change of address. Additionally, the appellant identified that his wife would not have made the call to DHS to change the address until at least November. The appellant also does not remember whether or not he received a bill from Rite Share prior to his move, thus making it impossible for him to dispute. However, further exploration of Premium share policy indicates that monthly bills are sent to the families approximately fifteen days prior to their due date. The due date is the first day of the coverage month. Thus, according to policy the appellant should have received the November bill in October. That would mean the appellant was sent the November bill to the RI address at which he was still residing. The appellant admittedly did not call Rite Share at any time, and thus did not dispute the bill even at that time. According to policy, the applicant is responsible for the entire month if they have received any coverage. On the first of November, when the appellant believes his wife would have contacted DHS, the appellant had already incurred responsibility for that entire month.

In summary, the appellant had three opportunities to change his address of record at DHS and to request closure. In August when he signed his lease with the new landlord to begin occupancy on November 1, 2012, he admittedly did not contact DHS. In September 2012 when the recertification was completed, he did not change his address. Following receipt of the November bill in October, the appellant did not change his address. Thus, per policy, the appellant would have been responsible for the November bill on the first day of November regardless of a subsequent call made in November. The appellant believes his wife did contact the Agency in November, but neither he nor his wife could provide any documentation or evidence. He was not able to state with certainty that this did occur, particularly given the two year time lapse. The Agency provided documentation that the appellant had not been in contact with the Agency since the September recertification, and the case logs showed no change of

address. The Agency continued to keep the MA opened and sent the December notice to the RI address of record. Thus, because the case remained open, the state of RI had continued to pay MA benefits for the family for the months of November and December. Although the appellant and his wife provided credible testimony, they by their own recounting, were unable to testify to a certainty of a phone call made to DHS, and they were unable to provide any evidence to support their claims. As a result, the appellant is responsible for the two months of premium bills incurred in 2012.

After a careful review of the Agency's policies, as well as the evidence and testimony provided, the Appeals Officer finds that the appellant is required to pay a past due Medical Assistance (MA) family premium bill of \$184.00. The appellant's request for relief is denied.

A handwritten signature in cursive script, appearing to read "Karen E. Walsh".

**Karen E. Walsh**  
Appeals Officer

**APPENDIX**

## **MEDICAL ASSISTANCE**

### **0348 RITE CARE PROGRAM**

#### **0348.40.05 Premium Share Requirements**

REV:02/2012

The following individuals/groups must pay a monthly premium to maintain coverage:

1. MA Waiver Families with income equal to or greater than one hundred fifty percent (150%) of the federal poverty income guidelines (FPL) and not exceeding one hundred seventy-five percent (175%) of the FPL
2. Children age one (1) to nineteen (19) with family income equal to or greater than one hundred fifty percent (150%) of FPL, and not exceeding two hundred fifty percent (250%) of the FPL
3. Pregnant Women with family income above two hundred fifty percent (250%) of the FPL and not exceeding three hundred fifty percent (350%) of the FPL.

The full State negotiated capitation rate will be billed to the pregnant woman by the health plan and in turn must be paid directly to the health plan by the pregnant woman.

4. Extended Family Planning recipients with family income above two hundred fifty percent (250%) of the FPL and not exceeding three hundred fifty percent (350%) of the FPL. The premium amount is determined as follows:

o Pregnant women whose countable family income is above two hundred fifty percent (250%) but not exceeding three hundred fifty percent (350%) of FPL must pay the full State negotiated capitation rate to the health plan in addition to the schedule of point-of-service co-payments.

o Extended Family Planning recipients whose countable Family income is above two hundred fifty percent (250%) but not exceeding three hundred fifty percent (350%) FPL must pay the full State negotiated Extended Family Planning premium for the particular health plan in addition to the schedule of point-of-service co-payments.

o There is no premium charged for an individual whose MA eligibility is based on the federal poverty level Income standard for a family size of one, such as when an aunt applies for MA for her nephew only, or when an SSI parent with one child applies for MA for the child only.

o There is no premium charged for RIW recipients, Extended MA recipients, IV-E and non IV-E foster children, or IV-E and

non IV-E adoption assistance children.

o For all others, the amount of the premium is Determined by countable family income as follows if:

Monthly Family Income Family Premium

over 150% and not greater than 185% FPL \$ 61.00 over 185% and not greater than 200% FPL \$ 77.00 over 200% and not greater than 250% FPL \$ 92.00

o Monthly premiums are not prorated. Therefore, a full monthly premium is due if the family receives MA coverage for any portion of a coverage month.

### ***0348.40.05.05 Non-Payment of Premiums***

REV:02/2012

Individuals and families with countable income under 250% of FPL who are subject to cost sharing requirements must pay a monthly premium in order to maintain MA eligibility as follows:

1. For new MA applicants, no premium payment is required for: the month in which the MA application is received by DHS; or the month following the month of application. For purposes of this policy section, new MA applicant means an individual who did receive MA at any time during the month of application or the month before the month of application. (For an MA application filed 11/21, no premium is charged for November or December.) Depending upon when an application is received by the Department and when it is approved, a member could be responsible for a premium for a month in which they did not know that they were eligible.
2. A re-applicant is treated like a current recipient. See "CHANGES IN COST SHARING STATUS" below. For purposes of this policy section, a re-applicant means an individual who received MA benefits at any time in the month of application, or the month prior to the month of application.
3. Payment of the initial premium is due on the first of the month following the date of the initial bill. The initial bill will be sent during the first regular billing cycle following MA acceptance, and, depending on the date of MA approval, be for(1) or more months of premiums due.
4. Ongoing monthly bills will be sent to the individual or family approximately fifteen (15) days prior to the due date. Premium payments are due by the first (1st) day of the coverage month. (Payment for the month beginning 1/1 through 1/31 is due by 1/1.)
5. If full payment is not received by the twelfth (12th) of the month following the coverage month, a notice of MA discontinuance is sent to the individual or family. MA eligibility is discontinued for all family members subject to

cost sharing at the end of the month following the coverage month. (If payment due on 1/1 is not received by 2/12, MA eligibility is discontinued effective 2/28.)

6. Dishonored checks and incomplete electronic fund transfers are treated as non-payments.

7. Individuals and families, who are discontinued for failure to pay a required premium are subject to a four (4) month restricted eligibility period, during which access to MA health coverage is denied. The restricted eligibility period applies to all members of the family financial unit who are subject to cost-sharing. It begins on the first of month after MA coverage ends and continues for four (4) full months. (If MA is discontinued effective 11/30, a restricted period of eligibility, during which MA is denied, will exist for the months of December, January, February and March sanctioned and disenrolled from MA coverage until balance is paid in full. Once balance is paid in full, sanction will be lifted and eligibility will be reinstated effective the first of the month following the month of payment. If payment is made more than 30 days after the close of the case, in addition to the payment, a new application will be required.

8. DHS has the authority to recover Medical Assistance benefit overpayment claims and cost share arrearages through offset of the individual state income tax refund in accordance with Sections 44-30.1-1, 44-30.1-3, 44-30.1-4 and 44-30.1-8 of the Rhode Island General Laws in Chapter 44-30.1 entitled 'Setoff of Refund of Personal Income Tax.' An example of a cost share arrearage is premium owed to the DHS by a beneficiary for a month in which Medical Assistance eligibility was active for at least one day.

See DHS policy section 0313 COLLECTION OF OVERPAYMENTS VIA STATE TAX REFUND OFFSET.

9. MA coverage shall be reinstated without penalty for otherwise eligible family members if all due and overdue premiums are received by the Department's fiscal agent on or before the effective date of MA discontinuance.

An exemption may be granted in cases of good cause, as provided below.

A restricted eligibility period may be shortened and MA eligibility re-established if: a) DHS determines that there was good cause for nonpayment of the premium and the individual remits all past due premiums; or b) the individual or family is no longer subject to cost-sharing requirements (e.g., family income decreases). Good cause means circumstances beyond a family's control or circumstances not reasonably foreseen which resulted in the family being unable or failing to pay the premium. Good cause circumstances include but are not limited to:

- o Serious physical or mental illness.

o Loss or delayed receipt of a regular source of income that the family needed to pay the premium.

o Good cause does not include choosing to pay other household expenses instead of the premium.

The state will also take action to collect premiums via tax offset as stated in Section 0313.

#### CHANGES IN COST SHARING STATUS

Medical Assistance recipients are required to report any changes, such as changes in income or family composition, which could effect the family's cost sharing status or premium share, within ten (10) days.

When such a change is reported in a timely manner, the following procedure is followed:

1. If the individual or family is moving from a "no cost sharing" status to a "cost sharing" status, no premium is due for the month in which the change is reported or for the following month. These months are referred to as exempt months. (e.g. If an increase in income is reported timely on 12/15, and as a result of the increased income, the family is now subject to premium payments, no premium is due for the exempt months of December or January.)

The initial premium is due on the first of the month following the exempt months. A bill for the initial premium will be sent approximately fifteen (15) days prior to the due date. Future premiums are due on the first of the coverage month.

If the premium is not paid in full and received by the Department's fiscal agent by the twelfth (12th) of the month following the coverage month, a notice of MA discontinuance is sent to the individual or family. MA is discontinued effective the last day of the coverage month for any MA eligible members who are subject to cost sharing. MA benefits shall be reinstated without penalty if all due and overdue premiums are received by the Department's fiscal agent before the effective date of MA discontinuance. A four(4) month period of restricted eligibility is imposed if payment in full is not received before the effective date of MA discontinuance.

2. If the amount of the required premium is increasing, the old, lower premium is due for the month in which the change is reported and for the following month. Follow steps listed in #1 above.

3. If based on a change in circumstances, the amount of the premium is decreasing or individual or family is moving from "cost sharing" to "no cost sharing", the monthly premium is re-calculated effective the month the change occurred, or the month the change was reported or discovered, whichever is

later. The individual's or family's bill is adjusted for the next regular billing cycle, and the case is evaluated to determine if, based on the change, any premiums not due were received by the Department. Any such payment received by the Department is applied to the family's past due premium bills, or refunded to the individual or family.

When a family does not report the change in circumstances within ten (10) days, the following procedure is used:

1. If the individual or family is moving from a "non cost sharing" status to a "cost sharing status", regular monthly premiums are due two months after the change is reported or discovered. (For example, if a family's reports in May that their income increased in January, the first regular monthly

premium would be due on July 1st.) A monthly bill is sent to the individual or family approximately fifteen (15) days prior to the due date. If not paid by twelfth (12th) of the month following the coverage month, a notice of MA discontinuance is sent to any MA eligible family member(s) subject to cost sharing requirements. MA is reinstated if all due and overdue premiums are received before the effective date of MA discontinuance.

The case is then evaluated to determine the amount of premiums which would have been billed if the change was reported within the required ten (10) day time period. This amount is treated as an overpayment received by the individual or family, and referred to the Collections, Claims and Recovery Unit for collection in accordance with provisions contained in Section 0112 of the DHS Rules.

2. If the individual's or family's premium share is increasing, the increased premium is due two months after the change is reported or discovered. Follow additional steps shown in #1 above.

3. If based on a change in circumstances, the amount of the premium is decreasing or individual or family is moving from "cost sharing" to "no cost sharing", the monthly premium is re-calculated effective the month the change was reported or discovered. The individual's or family's bill is adjusted for the next regular billing cycle, and the case is evaluated to determine if, based on the date the change was reported or discovered, any premiums not due were received by the Department. An adjustment is not made, and no refund is issued for any premiums paid prior to the month the change was reported or discovered.

STATE FUNDED PREGNANT AND EFP WOMEN (250%-350% FPL)

Pregnant Women or Extended Family Planning Women whose incomes are above 250% but not exceeding 350% will be dropped from the Rite Care Program if they fail to make premium payments for three (3) consecutive months or if they

habitually fail to make timely payments in accordance with health plan payment policies.

Although DHS will disenroll these members, the health plan has policies and procedures to:

- o notify the enrollee that failure to pay premiums will result in cancellation of coverage;

- o send notification thirty (30) days prior to the member's termination. This notice shall include information on how and when the past and current due premiums must be paid to avoid coverage termination;

- o notify DHS fifteen (15) days prior to the last day of the third month in which no payment is received.

The health plan may continue to seek payment of past due premiums from former members following their disenrollment. The health plans have written policies and procedures for past due premiums collection and must make these know to member at the time of enrollment.

## **0318 MEDICAL ASSISTANCE REDETERMINATION**

### **0318.05 REDETERMINATION OF MA ELIGIBILITY**

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.

Although the newborn is deemed eligible at birth, the birth itself is a change in household composition that always requires redetermination of continuing eligibility for the mother, the newborn and the rest of the family, either for FIP or Medical Assistance only.

## 0318.10 REDETERMINATION PROCESS

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

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.

### **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.