

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
APPEALS OFFICE - LP Bldg.
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Date: November 17, 2014

Docket #14-1350
Hearing Date: October 21, 2014



ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been decided in your favor. 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 0348.40.05.05 Non-Payments or Premiums
SECTION 0348.40.05 Premium Share Requirements

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: Christine Mitchell, Sandra Cipriano, Denise Tatro, and Vincent Guglielmino.

Present at the hearing were: You, and Agency representative Christine Mitchell.

ISSUE: Is appellant required to pay, in full, a past due Medical Assistance (MA) bill of \$919.00?

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 original closure notice is dated November 14, 2011 and indicates that the case will close on November 25th because the appellant identified she wanted closure.
- The Agency got a letter from the client on the same date, and it indicated that she was requesting closure.
- The Agency has not seen the actual bill because it comes through Rite Share.
- There is no record of how the money accumulated, as the Agency does not get copies of the bills.
- It appears that the premiums have built up over some time.
- The record shows that she first applied for insurance January 14, 2005 just for one child.
- It closed August 31, 2005.
- She applied again September 6, 2005 requesting insurance only for the child.
- All applications were only for the one child as the mother was over the income guidelines.
- On July 8, 2011 it changed when the appellant was working a Per Diem nursing job, and she was collecting unemployment receiving \$578 per week plus her per diem.

- She was billed \$92.00 per month, and this ended on November 30, 2011.
- The Agency is unable to get any copies of any old bills.
- She might have made some payments in August 2005.
- If the Agency adds up all the premiums showed from 2003 to 2011, the total amount calculated comes to \$917.00, if you add \$122.00 which would account for two returned checks noted to have been returned in August 2005. This \$917 would then be \$2.00 different from the final bill (bill received July 2014). This might have been added on for processing.

The appellant testified:

- This last bill (July 2014) is for \$919.00 and she does not understand how it is so high.
- She doesn't believe that she didn't pay that many bills, so that she could not owe that much.
- She did get monthly bills and thought her premiums would have been about \$75.00 if she remembers correctly.
- She has no evidence of any kind except her resume'.
- She may have had coverage as far back as 2003 to 2005 as her employer did not offer coverage, so while working for [REDACTED] Pediatrics, she and her three children probably had coverage.
- The children definitely did have some kind of coverage.
- She worked at [REDACTED] Hospital from about 2005 until May 2011 and had her own company insurance then.
- She thinks she actually started the job in March 2011.
- She did get laid off in May 2011, and was unemployed all summer.
- Around that time, (May 2011) she asked to have health coverage for her daughter.
- She had only one child eligible for Rite Care (in 2011), but she did not use it, and had applied for the insurance for just that short period.

- She started a new job around September, and thought she had cancelled around that time, but agrees that the DHS note is probably correct.
- She agrees that the CLOG (identifying November closure) is probably correct, as she did write a letter to request closure.
- So, she only used the insurance for a few months-June through November when she was unemployed.
- She has not applied for it since then, because she has private insurance.
- She does not dispute that in August 2005 she had some returned checks possibly due to nonpayment and financial issues at the time.
- She has a resume' which shows her job history, but some of it is guess work, as she prepared it after the fact from memory for her 2011 job.
- She has gotten the same ongoing bill, but she does not know when and why the premium got so high.
- She had one job and three children, and cannot always remember everything that happened.

FINDINGS OF FACT:

- A Closure notice dated November 14, 2011 informed the appellant that her Medical Assistance (MA) eligibility and family premium would end on November 25, 2011 because she had "asked the Department to close her (your) case." The notice further reads, "We will let you know if you have any MA premiums that are overdue or if we owe you a refund for past payments."
- A Monthly Premium/Cost Share bill sent to the appellant, and dated July 11, 2014, shows a previous balance of \$919.00 in arrears. It further identifies that if two payments are missed, MA eligibility will be unavailable for four months.
- A timely request for hearing date stamped August 13, 2014 was submitted by the appellant. There was no response from the Agency on the statement of complaint.

- A second copy of a request for hearing included the Agency's response which read "client requested closure on 11/14/2011; and, the client had a bill for the cost share for Sept.2011, Oct.2011, and Nov. 2011."
- The hearing was held on October 21, 2014.
- Following the hearing, the record was reopened to allow further evidence. Specifically, additional evidence was requested of the Agency in order to fully develop the record. The Agency was allowed until November 7th to submit additional requested evidence. The appellant was allowed until November 13th to respond to the evidence submitted.
- No additional evidence was forthcoming from either the Agency or the appellant, and the record of hearing was closed on November 13, 2014.

CONCLUSION:

The issue to be decided is whether the appellant is required to pay, in full, a past due Medical Assistance (MA) family premium bill of \$919.00.

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 appellant had received MA benefits from 2003 through 2011 intermittently. There is no dispute that the appellant had sent a letter to the Agency in November 2011 requesting her final case closure. The most recent Premium share bill, dated July 11, 2014 indicates that the appellant is \$919.00 in arrears. The Agency contends that the appellant owes a total of \$919.00 as a result of an accumulation of ongoing missed premiums over a long period of time. They were unable to present any single bills, nor locate any cumulative record of accounting. They did present a Cost Share history which displayed the amount of the premiums which would have been required in corresponding months from 2003 through 2011. This readout identified information pairing the amount of a premium which would be due in any given month. For example, in December 2003 the premium required was \$61.00; and in October 2011, the premium would have been \$92.00. There were no corresponding notices or displays, or Clogs which could correlate premiums to actual bills.

The appellant does not dispute that she might have owed some monies on her final bill. She does question the veracity of the final bill, as she argues that she had been paying her bills ongoing and sometimes intermittently, but she does not know how it could have possibly gotten as high as the amount presented. She has been receiving a bill since her closure, but does not know if the last bills received in 2011 reflected the same

amount currently requested (in July 2014). She has no other evidence to present due to the three year time lapse and her difficult living situation at the time she incurred the bills. The appellant testified, and the notice confirmed, that she had asked for closure in November 2011. The closure notice further expressed that if the appellant had any past MA premiums or if she was owed any refund she would be notified. The Agency was unable to produce any subsequent notice which identified a past premium and the amount of such premium owed. Further exploration of the evidence submitted by the Agency indicates that the appellant's MA case was closed repeatedly on at least 8 different occasions between 2003 and 2011. Six of the closings correlate with immediate reopenings the following month, so that the appellant lost no actual coverage. One CLOG noted that in October 2005 the case was reopened per systems as the "premium had been paid." The record of hearing was held open in order to allow the Agency to explain the six immediate reopenings. The Agency was unable to provide any closure notices, or subsequent eligibility notices which might have shed some light on why the Agency would have allowed immediate reopening if the appellant owed past bills. The record reflects two other periods of MA closure. A Clog associated with the first closure in July 2004 indicates the appellant is closed for non-payment. She is reopened five months later. The existing bill dated July 2014 included language which identified that the appellant would not be eligible for MA for four months in the event she missed two payments, and that she would owe the monies in arrears. This then, could explain the 2004 break in services, if the appellant owed monies at the time. It does not explain why the Agency would reopen the services in January 2005 if she had not brought her account current. A second break in MA services occurred between January 2006 and June 2011, a period of time which approximates the appellant's recollection of having had private insurance through her position at Westerly Hospital, from which she was laid off around May 2011. She recollects requesting insurance again around that time, and the record reflects that MA coverage began again in July 2011, and ended in November 2011 when the appellant requested closure. Neither the appellant nor the Agency could confirm any payment history or provide any paper trail to reflect the appellant's payment history.

Examination of policy around this issue identifies that an MA case, upon receipt of all due and overdue premiums, may be reopened. The record indicates that the appellant's case was reopened on several occasions. Without any conflicting testimony from the Agency, there is no other explanation for the appellant's benefits to be reopened, unless she had continually brought her bills current which is identified on one occasion in October 2005.

The Agency also contends that if one added all the premiums identified in the cost share history readout between 2003 and November 2011, and then added another \$122 which had been the amount of two checks reopened in July 2005; they would total \$917, which is just \$2.00 short of the \$919 requested in the final bill. Although this is a plausible guess, there is no corresponding documentation which ties in those amounts with any specific bills.

Further exploration of the evidence produced a second request for hearing attached to the first hearing form. This request copied the appellant's complaint, but also contained a copy of the Agency's response which was signed by a DHS Supervisor. This was not noted or discussed at hearing. The supervisor writes that the "client requested closure November 14, 2011." She further explains that the "client had a bill for cost share for September 2011, October 2011 and November 2011." The Agency representative does not make mention of any former bills other than the most recent three months. In examining policy, an applicant applying for Rite Care coverage would not receive a premium for the month of application, nor would she receive billing for the following month. The Agency identified that the appellant had been closed to MA from sometime in 2006 until her application again on July 8, 2011. If the appellant had reopened her MA at that time, and was not billed for the month of application, nor was she billed the following month, she would be responsible for the MA premium from Sept onward. The appellant herself closed her case in November 2011, as noted in the record. This would mean she would have avoided a December bill as she had formally requested closure prior to utilizing any premiums during that month. This then would support the Agencies note that the appellant owed three months. The evidence presented indicates that premiums in 2011 would have been \$92.00 per month. Thus, the total bill could not have totaled more than \$276.00 for the three months.

In summary, the appellant has been receiving an ongoing premium bill for several years, as a result of a bill incurred for her use of MA benefits which closed in November 2011, per her request. The appellant did not dispute that she might have some bill, but did not feel responsible for a bill totaling \$919.00-the amount of the last bill received in July 2014. The Agency was not able to demonstrate any correlation between the amount billed and prior months owed by the appellant. The Agency demonstrated a long history by the appellant of use of MA benefits, but the record did not support that the appellant had accumulated any ongoing bills prior to her case being reopened in July 2011 after a five to six year break. MA policy supported the appellant's contention that she had paid her past premiums, as her case was repeatedly reopened during the periods from 2002 through 2005, which is departmental policy, upon receipt of owed or past premiums. The Agency noted that the appellant had reopened her case in July 2011. The Agency's statement on the request for hearing form further indicated that the appellant had not paid her final bill for the last three months ending in November 2011. Evidence submitted during hearing indicated that the amount of the premiums in 2011 were \$92.00. Thus, the appellant is not required to pay, in full, a past premium bill of \$919.00, but will be held responsible for the last three months of use, totaling \$276.00.

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 not required to pay, in full, a past due Medical Assistance (MA) family premium bill of \$919.00. The appellant's request for relief is granted.

ACTION FOR THE AGENCY:

The Agency is to rescind the MA family cost share premium bill of \$919.00, the total indicated on the last bill dated July 11, 2014. The appellant is to be billed for the final three months of use only-September, October, and November 2011 at the rate of \$92.00 per month.

A handwritten signature in cursive script that reads "Karen Walsh".

Karen E. Walsh
Appeals Officer

APPENDIX

MEDICAL ASSISTANCE

0348 RITE CARE PROGRAM

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 not 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.

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.

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.

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.