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: December 19, 2014

Docket # 14-1802
Hearing Date: December 2, 2014

[redacted]

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:

MEDICAID CODE OF ADMINISTRATIVE RULES (MACR)

0302 Medicaid Application-Integrated Health Care Coverage Groups D. Period of Eligibility

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 (the appellant), HSRI (Health Source Rhode Island) representative Lindsay Lang, and Agency representatives: Sandra Cipriano, and Nancy DelPrete.

Present at the hearing were: You, Lindsay Lang, and DHS Agency Representative Sandra Cipriano.

ISSUE: Should the appellant receive retroactive Medicaid coverage beginning September 1, 2014?

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:

- She (the appellant) received the August 16th (2014) Medicaid termination notice.
- The appellant and the HSRI representative agree that she did go into HSRI and submit the documents requested by August 23rd.
- The Agency does not have record of her having sent in the hard copies the first time in early August.
- The case had been closed, when the documents were presented they put her into a different category and she is now in a QHP (qualified health plan).
- The Agency is now trying to look back to see if they should have gone back to September 1st and whether it is possible to reinstate her for September in the Medicaid world.
- They will explore this during the held open period.

The HSRI representative testified:

- The timing is at issue, in that the appellant received her Medicaid termination notice on August 16th, and there is a record of her coming in to the office on August 23rd to verify her income.

- HSRI was unable to verify her statements that she faxed in the original paystubs in early August, but the record did indicate that she (the appellant) came in to the 70 Little Drive location with her paystubs on August 23rd.

- They will explore the record to determine whether or not she did come in on August 2nd with her paystubs.

- Those paystubs were not processed until the 2nd of September, and a second notice was not provided until the 6th of September.

- The question then is what should have happened from August 23rd or very soon after and prior to her Medicaid being terminated at the end of August.

- The September 6, 2014 notice of eligibility states she is eligible for a special enrollment period and that her previous coverage had been Medicaid, and her new determination was for a QHP. It further identified that she is not Medicaid eligible because her household income is higher than Medicaid requirements, and her coverage would begin on October 1, 2014.

- If her Medicaid coverage is determined to terminate at the end of August, policy would allow her to have a special enrollment coverage period which would begin on September 1st if she chooses, because she lost minimal essential coverage.

- She could begin with a QHP in September, but she would have to pay for this coverage. She is already enrolled in a QHP as of October and has paid for October and November and December.

- She is eligible for tax credits, and would owe the past premium.

The appellant testified:

- She received a letter in late July from HSRI, asking for verification of income.

- She mailed in a hard copy of her pay stubs and faxed a copy to the number on the letter on the second of August.

- She remembers this date specifically because she sent a separate bill on the same day with the check dated August 2nd.

- She followed up with a call when she received the August 16th income verification letter, to identify that she had already sent the pay stubs.

- She was told her information had not been processed yet, and that she should bring a hard copy to the office in Providence.

- On August 23rd, she brought her information in, and they told her she was all set.
- She called again in early September, and they told her they still had not obtained the earlier hard copies, and they had just processed the recent information as well, that she had brought to them in August.
- She did not receive anything from them (HSRI) until early September, when she received notice that Medicaid had ended and she was eligible for a QHP in October.
- If HSRI locates her original paystub information she would like to receive confirmation of this.

FINDINGS OF FACT:

- A Medicaid termination notice dated August 16, 2014 notified the appellant that her benefits would be terminated on August 31st for lack of income verification.
- The appellant filed a timely appeal on September 16, 2014.
- A hearing was held on September 16, 2014 at the Wakefield DHS office.
- Per the appellant's request the record of hearing was held open until December 16, 2014 for additional evidence to be submitted by HSRI. No evidence was received.
- The appellant brought her paystubs to the HSRI office on August 23, 2014.
- The appellant's Medicaid benefits terminated on August 31, 2014 for failure to submit income verification.
- The appellant received a notice dated September 6, 2014 which allowed for enrollment in a QHP (qualified health plan) to begin on October 1, 2014, and which identified that she had had previous Medicaid coverage.

CONCLUSION:

The issue to be decided is whether the appellant should receive retroactive Medicaid coverage beginning on September 1, 2014?

Per Medicaid policy, Medicaid ends when the individual is determined to no longer meet the program's eligibility requirements and proper notification has been given or the beneficiary fails to renew eligibility as required. Medicaid benefits cease on the last day

of the ten day notice period when eligibility is determined to no longer exist. Further exploration of policy indicates that the Policy demands that beneficiaries must receive adequate and timely (10-day) notice of decisions which result in an adverse action. Due process, a constitutional right, further requires that the notice should inform a person about changes in benefits, cite law, and identify when the change will happen.

In this case there is no dispute between agencies (DHS and HSRI) and the appellant, regarding receipt by the appellant of a Medicaid termination notice dated August 16, 2014 which identified that Medicaid eligibility would end on August 31, 2014. There is no dispute either that the appellant provided paystubs at the HSRI facility on August 23, 2014. The DHS Agency argues that those paystubs supported the termination as they documented that the appellant was no longer eligible for Medicaid due to her household income which was greater than Medicaid requirements. They further noted that they were unclear as to whether her Medicaid should have been reinstated and whether a second notice should have been generated. The Agency agreed to explore this possibility during the hold open period. As of this date, the Agency has not withdrawn their initial denial.

The HSRI representative acknowledged that the appellant did come into their facility on August 23, 2014 and did provide paystubs which were not entered into the system until early September. They identified that a second notice was sent out on September 6th which identified that the appellant would be eligible to purchase a QHP (qualified health plan) which would begin on October 1, 2014. They further testified that due to considerations for a special enrollment period allowed by HSRI when a beneficiary has lost all insurance coverage, they could retroactively cover the appellant as of September 1, 2014, but she would be responsible for the past premium. They testified that the appellant is now enrolled in a QHP as of October 1st, and has paid her premiums through December.

The appellant contends that she responded on August 2, 2014 to a July notice requesting income verification. She reported that she both faxed and sent a hard copy of her paystubs as requested to the address and fax number on the initial notice. She further testified that upon receipt of the August 16th termination notice she immediately contacted HSRI directly and was informed that they did not have evidence of the documents, and that she would need to come into the facility with her stubs. She did this on August 23rd, and testified that she was told that she was "all set." In early September she again contacted HSRI who informed her they had not processed her documents in August, but were processing them in early September. She received a subsequent notice dated September 6th, which informed her that she formerly had Medicaid and would be eligible for a QHP in October. The appellant appealed the lack of coverage in September, as she utilized her medical coverage after understanding that everything was "all set".

Further exploration of the evidence revealed that the initial notice requested verification of income from the appellant by August 31st. Policy allowed for the benefits to cease at the end of the eligibility period. However, the specific issue addressed in the notice was

household income verification. The appellant gave credible testimony that she had in fact met that criterion on August 2nd prior to the August 16th notice when she faxed and sent a hard copy of her paystubs for verification. Regardless, it was stipulated by all parties and supported by additional evidence that the appellant at least submitted in person the verifications needed on August 23rd prior to the deadline. After having fulfilled the obligation of the first notice, HSRI had an obligation to process the documents immediately, which in turn should have generated a new notice. It is unclear why the documents were not entered into the computer system until after September 1, but it appears that they were not entered for a period of 10-14 days following their receipt. Because the requirements of the first Medicaid denial were met prior to the termination of benefits, the system should have made the appellant "whole", restored her benefits, and then determined her "new" eligibility based upon the information received. In the event a new consideration, in this case-"household income was greater than Medicaid requirements"-then the new notice would need to reflect the "new" reason for termination. On September 6th the subsequent notice revealed only that the Medicaid benefits had ceased, and the appellant would have an opportunity to obtain insurance the following month. The appellant never had an opportunity to dispute any notices related to the consideration of her income as it related to the paystubs and the Medicaid regulations.

In summary, the appellant received an August 16, 2014 Medicaid denial notice indicating her benefits would be terminated on August 31st due to lack of verification of income. Both DHS and HSRI agreed that the appellant had submitted the documents requested to HSRI, at least by August 31st. Her benefits were still terminated for reasons other than those cited in the notice. In this, the appellant was denied due process which would have allowed restoration of her initial benefits, followed by a subsequent notice allowing for a 10-day notification, inclusion of the reason and law for closure, and defining the time frames within which she would be losing her benefits. As a result, the appellant was not provided due process, and did not correctly have restoration of her Medicaid benefits in September. She was qualified for and is receiving a QHP through HSRI for the months of October and moving forward, resulting from a reassessment of her income.

After a careful review of the Agency's policies, as well as the evidence and testimony provided, this Appeals Officer finds that the appellant was not provided due process. The appellant's request for relief is granted.

ACTION FOR THE AGENCY:
The Agency is to restore the appellant's Medicaid benefits as of September 1, 2014.

Karen E. Walsh
Appeals Officer

APPENDIX

MEDICAID CODE OF ADMINISTRATIVE RULES
0302 Medicaid Application-Integrated Health Care Coverage Groups

D. **Period of Eligibility**
REV: June 2014
Written notice is provided to each applicant stating the Medicaid agency's eligibility decision, the basis for the decision, and an applicant's right to appeal and request a hearing. In instances in which the applicant is determined to be eligible, a notice is provided indicating the length of time the applicant will remain eligible – the *"eligibility period"* -- until before a renewal of continuing eligibility is required. The period of Medicaid eligibility for IHCC group members is as follows:
(1) General eligibility period. When an individual is determined eligible for Medicaid, eligibility exists for the entire first month. Therefore, eligibility begins on the first day of the month in which the individual is determined eligible. Medicaid ends when the individual is determined to no longer meet the program's eligibility requirements and proper notification has been given or the beneficiary fails to renew eligibility as required. Medicaid benefits cease on the last day of the ten (10) day notice period when eligibility is determined to no longer exist. Individual and couple cases remain eligible for Medicaid for up to a maximum of twelve (12) months. Certifications may be for LESSER periods if a significant change occurs or is expected to occur that may affect eligibility.
(2) Special eligibility period – Medically-needy. In cases where the *flexible test of income* policy is applied, eligibility is established on the day the excess income is absorbed (i.e., the day the health service was provided). Eligibility is for the balance of the six (6) month period. Medically-needy eligibility continues for the full six (6) months or the balance of the six (6) month period.
(3) Medicare Premium Payment Program. Individuals eligible for benefits as a Qualified Medicare Beneficiary (QMB), a Special Low Income Medicare Beneficiary (SLMB) or a Qualified Working Disabled Individual (QWDI) are certified for a 12-month period. A Qualifying Individual (QI-1 or QI-2) is certified to the end of the calendar year.

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.