STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF HUMAN SERVICES
APPEALS OFFICE
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Docket # 14-1809
Hearing Date: December 3, 2014

Date: December 10, 2014

[redacted]

ADMINISTRATIVE HEARING DECISION

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

ACCESS TO MEDICAID COVERAGE UNDER THE AFFORDABLE CARE ACT
PROVIDER MANUAL: 1306 Renewal of Eligibility for Medicaid Affordable Care Coverage Groups
Section: 1306.06 Responsibilities of Medicaid Members

1308 Verification of Medicaid Affordable Care Coverage Group
Section: 1300.08 One Application, No Wrong Door, Medicaid First

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) and Michael Richardson and Cheryl Tremblay Agency Supervisors and the Policy Unit.

Present at the hearing were: You (the Appellant) and Michael Richardson, Agency Supervisor.

ISSUE: Was the Appellant's Medicaid benefits properly terminated for not verifying her household income?

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

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

DISCUSSION OF THE EVIDENCE:

The Agency Supervisor testified:

- On August 16, 2014 the Executive Office of Health and Human Services (EOHHS) with the Department of Human Services (DHS) issued a "Medicaid Termination Notice" to the Appellant, informing her that her benefits will be terminated due to her household income could not be verified and income verification period had expired. The Appellant's eligibility would end August 31, 2014.
- The Appellant was requested to provide some income verification to the agency but nothing was ever received, so a termination notice issued.

The Appellant testified:

- Right after the Appellant received her termination notice, she called HealthSource Rhode Island (HSRI) to address the matter.
- The Appellant spoke with an HSRI representative and provided updated income verification over the telephone. She was told that due to her obtaining a new job that she no longer qualified for the plan that she was on and that she could either choose to enroll in a new plan or enroll in her new employer's health plan.
- The Appellant choose to enroll in her new employer's health coverage plan.
- The Appellant did verify with the HSRI representative that she was speaking to that her coverage would continue and end on September 30, 2014.
- The Appellant stated that she was prompted by the HSRI representative to do a "screen shot" of her HSRI dashboard screen that showed that the Appellant's eligibility would now end on September 30, 2014.
- The Appellant had concerns that since she had two doctor's appointments in the month on September, one an annual doctor's appointment with her general practitioner which she has not received a bill as of yet and one with a physician that she has already received a bill for $367.00.
- The Appellant had applied for health insurance the first of this year through HSRI and due to her income level was found eligible for Medicaid.

FINDINGS OF FACT:

- On August 16, 2014 the Executive Office of Health and Human Services (EOHHS) with the Department of Human Services (DHS) issued a "Medicaid Termination Notice" to the Appellant, informing her that her benefits will be terminated due to her household income could not be verified and income verification period had expired. The Appellant's eligibility would end August 31, 2014.
- The Appellant was requested to provide some income verification to the agency but nothing was ever received, so a termination notice issued.
- The Appellant spoke with an HSRI representative and provided updated income verification over the telephone. She was told that due to her obtaining a new job that she no longer qualified for the plan that she was on and that she could either choose to enroll in a new plan or enroll in her new employer's health plan.
- Appellant opted to enroll in her employer's health plan, which started October 1, 2014 once she verify with the HSRI representative that she was speaking to that her coverage would continue and end on September 30, 2014.
- The Appellant stated that she was prompted by the HSRI representative to do a "screen shot" of her HSRI dashboard screen which the Appellant presented at Hearing, showing that the Appellant's eligibility would now end no September 30, 2014.
- The Appellant has concerns that since she had two doctor's appointments in the month on September, one an annual doctor's appointment with her general practitioner that she has not received a bill for as of yet and one with a physician that she has already received a bill for $367.00.

CONCLUSION:

The issue to be decided is whether the Appellant's Medicaid benefits properly terminated for not verifying her household income?

The agency reviewed the Appellant's Medical Assistance and notified that her that her household income needed to be verified otherwise she would no longer be eligible for Medicaid. The Appellant was informed of the agency's need for this information by a "Medicaid Termination Notice" that issued on August 16, 2014 to the Appellant's address of record. The DHS Supervisor who attended the Hearing testified that there was nothing on file that the Appellant had contacted his DHS Office after the "Medicaid Termination Notice" issued on August 16, 2014.

> Duty to Report -- Medicaid members are required to report changes in eligibility factors to the Medicaid agency within ten (10) days from the date the change takes effect. Self-reports are permitted through the eligibility system on-line portal. Medicaid members also may report such changes in person, via fax, by mail, or telephone with the assistance of Contact Center or DHS agency representative, or Navigator. Failure to

report in a timely may result in the discontinuation of Medicaid eligibility.
§ 1306.06 (2) Responsibilities of Medicaid Members

The Appellant testified that she had applied for healthcare coverage and was found eligible for Medicaid when she applied through HSRI in February of 2014. The Appellant contacted HSRI soon after receiving her August 16, 2014 "Medicaid Termination Notice" and was allowed to update and submit her household income. The Appellant was told by the HSRI representative that since she updated her income, her present eligibility would end September 30, 2014 and not August 31, 2014 as her Notice stated. The HSRI informed the Appellant that since her income has changed she would no longer be eligible for Medicaid and would have to pick a new plan or looking into her employer sponsored healthcare coverage; she choose to obtain healthcare cover through her employer. After being prompted by the HSRI representative, the Appellant printed the computer screen of her RIHS dashboard, which reflects the date in which the Appellant's eligibility ends (September 30, 2014). Having been assured that the Appellant would maintain healthcare coverage until September 30, 2014, the Appellant had kept her scheduled doctor's appointment that had been made for the month of September. In October, the Appellant started receiving bills for her doctor visits that she attended in September of 2014.

Once having received her "Medicaid Termination Notice", the Appellant called RIHS, where she originally applied for healthcare benefits and spoke with a representative. The Appellant was informed that she could provide the needed income information over the telephone. Having complied with the August 16, 2014 Notice, the Appellant relied on what she was informed by the HSRI representative, that her healthcare coverage would continue until September 2014 and not August 31, 2014. Due to not having an HSRI representative present at the Hearing, the Appellant's testimony could not be confirmed or denied.

The Access to Medicaid Coverage under the Affordable Care Act, § 1300.08 One Application, No Wrong Door, Medicaid First, allowed the Appellant to applied for healthcare coverage and was found eligible for Medicaid by HSRI. When she received her "Medicaid Termination Notice" of August 16, 2014, she thought that it was only proper to contact HSRI again in hopes to resolve the issue of verifying her income. While speaking with a HSRI representative, the Appellant was never told that she was speaking to the wrong agency/office/department. The Appellant's notice of August 16, 2014 does not indicate that she is required to contact a DHS- Medical Assistance representative or even provides a DHS Office telephone number. The August 16, 2014 notice does provide a telephone number and that belong to HealthSource Rhode Island (855-712-9158).

§ 1300.08 One Application, No Wrong Door, Medicaid First
• One application --The State's affordable care system uses one streamlined application to evaluate eligibility for all types of coverage, including Medicaid.
• No Wrong Door -- Applicants can apply on-line on their own through links on the EOHHS and DHS websites or HealthSourceRI.com, or with the

assistance of a Navigator, or DHS agency or Contact Center representative. Applications are accepted through the web-portal, in

person at the Contact Center and DHS field offices and by mail and telephone.

• Medicaid First -- Once an application is submitted, the system tests for Medicaid eligibility first. If an applicant is found ineligible for Medicaid, the system applies the eligibility rules for federal premium tax credits, cost-sharing reductions and other subsidies. When no forms of assistance apply, the applicant still has the option to shop for a qualified health plan through Healthsource RI that meets the applicant's coverage needs.

In summary, on August 16, 2014 the Appellant received a "Medicaid Termination Notice" indicating that the Appellant's household income could not be verified and the income verification period had expired; furthermore her eligibility for Medicaid would end on August 31, 2014. Shortly after receiving this Notice, the Appellant calls HealthSource Rhode Island and spoke with a representative. At this time the Appellant was allow to provide her household income over the telephone and was told that due to her change of income, she would no longer eligible for Medicaid as of September 30, 2014. The HSRI representative informed the Appellant that she needed to either could pick a new healthcare policy or apply for her employer's sponsored healthcare insurance. Having been assured that she had retained her Medicaid healthcare coverage until September 30, 2014, the Appellant kept and went to her scheduled doctor appointments in the month of September 2014. In October of 2014, the Appellant started receiving medical bills. The Appellant called HSRI after receiving her August 16, 2014 Notice in order to verify her household income since HSRI is where she applied for healthcare and was approved for Medicaid. The only telephone number on the August 16, 2014 notice belongs to HSRI. Had the Appellant been told that she had contacted the wrong agency/office/department and that she needed to contact a DHS Office, she would have. One of the most important facets of implementing the Affordable Care Act is assuring the ease and accessibility to Medicaid coverage by insuring the "no wrong door" policy. This Appellant and everyone else that applied for healthcare coverage could have applied in person or by telephone through their local DHS Office or HSRI, they could have applied by means of a paper application or electronically on-line; the point being stressed is that there is no wrong door. The information that the Appellant submitted to HSRI after receiving her August 16, 2014 notice should have reached the Medicaid Office, unfortunately it had not, no fault of the Appellant.

After a careful review of the Agency's policies, as well as the evidence and testimony given, this Appeals Officer finds that the Appellant should have been found eligible for Medicaid until September 30, 2014. The Appellant's request for relief is therefore granted.

ACTION FOR THE AGENCY:

The Agency is to rescind the August 16, 2014 "Medical Termination Notice" and per the Appellant's HSRI dashboard screen shot and what the Appellant was told by a HSRI

representative, will have her Medicaid eligibility ending on September 30, 2014. The Agency shall issue a new Notice informing the Appellant of the September 30, 2014 closure date. These actions are to be completed within two weeks of the date of this decision.

Pursuant to DHS policy general provisions § 0110.60.05, action by this decision and completed by the Agency Representative must be confirmed in writing to this Hearing Officer

Thomas Bucacci
Appeals Officer

APPENDIX

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES

1306.06 Responsibilities of Medicaid Members

Medicaid members must ensure that the Medicaid agency has access to accurate and complete information about any eligibility factors subject to change at the time of the annual renewal. Accordingly:

1. Consent – At the time of the initial application or first MAGI-based renewal, Medicaid members must provide the Medicaid agency with consent to retrieve and review any information not currently on record pertaining to the eligibility factors subject to change through electronic data matches conducted through the State's affordable overage eligibility system. Once such consent is provided, the Medicaid agency may retrieve and review such information when conducting all subsequent annual renewals.

2. Duty to Report -- Medicaid members are required to report changes in eligibility factors to the Medicaid agency within ten (10) days from the date the change takes effect. Self-reports are permitted through the eligibility system on-line portal. Medicaid members also may report such changes in person, via fax, by mail, or telephone with the assistance of Contact Center or DHS agency representative, or Navigator. Failure to report in a timely may result in the discontinuation of Medicaid eligibility.

3. Cooperation – Medicaid members must provide any documentation that otherwise cannot be obtained related to any eligibility factors subject to change when requested by the Medicaid agency. The information must be provided within the timeframe specified by the Medicaid agency in the notice to the Medicaid member stating the basis for making the agency's request.

4. Voluntary Termination -- A Medicaid member may request to be disenrolled from a Medicaid health plan or to terminate Medicaid eligibility at any time. Disenrollment results in the termination of Medicaid eligibility. Once Medicaid coverage is terminated, the penalties established under the individual mandate in the federal Affordable Care Act of 2010 apply unless the former Medicaid member obtains an alternate form of health insurance coverage.

5. Reliable Information – Medicaid members must sign under the penalty of perjury that all information provided to the Medicaid agency at the time of application and any annual renewals thereafter is accurate and truthful.

1300.08 One Application, No Wrong Door, Medicaid First

- One application --The State's affordable care system uses one streamlined application to evaluate eligibility for all types of coverage, including Medicaid.
- No Wrong Door -- Applicants can apply on-line on their own through links on the EOHHS and DHS websites or HealthSourceRI.com, or with the assistance of a Navigator, or DHS agency or Contact Center representative. Applications are accepted through the web-portal, in person at the Contact Center and DHS field offices and by mail and telephone.
- Medicaid First -- Once an application is submitted, the system tests for Medicaid eligibility first. If an applicant is found ineligible for Medicaid, the system applies the eligibility rules for federal premium tax credits, cost-sharing reductions and other subsidies. When no forms of assistance apply, the applicant still has the option to shop for a qualified health plan through HealthSource RI that meets the applicant's coverage needs.

Rules and Regulations Pertaining to the Rhode Island Health Benefits Exchange [R23-1-1-ACA]

7.6 Voluntary Termination. The Exchange shall terminate enrollment at any time upon the request of an enrollee. Effective termination dates for voluntary termination shall be established by the Exchange.

7.7 Notice. The Exchange will provide an enrollee written notice of an involuntary termination that shall include the basis of the termination at least thirty days prior to the effective date of the termination.

7.8 Effective Date of Termination.

(a) *Voluntary terminations.*

(1) Upon a voluntary termination request submitted at least fourteen (14) days prior to the end of the month coverage shall be terminated at the end of the month. Coverage shall be terminated at the end of the following month if the termination request is submitted less than fourteen days prior to the end of the month.

(2) The Exchange may grant a different termination date if the request is submitted at least fourteen (14) days prior to the proposed termination date.

(3) The Exchange has discretion to grant an earlier termination date, on a case by case basis.

(4) If the enrollee requests coverage termination due to eligibility for Medicaid, coverage will terminate the day before Medicaid coverage begins.

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.