



Rhode Island Executive Office of Health and Human Services
Appeals Office, 57 Howard Ave., LP Building, 2nd floor, Cranston, RI 02920
phone: 401.462.2132 fax: 401.462.0458

February 18, 2015

Docket # 14-2138
Hearing Date: January 15, 2015



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 regulation(s) were the matters before the hearing:

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES (EOHHS)
MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)
SECTION: 0110.25 Legal Basis for Appeals and/ or Hearings
SECTION: 0110.30 Definition of a Hearing
SECTION: 0110.30.05 The Right to Request a Hearing

THE DHS POLICY MANUAL: MEDICAL ASSISTANCE
SECTION 0348.05 Overview of the Program
SECTION 0348.85 Member Disenrollment

The facts of your case, the Agency regulations, 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 Agency representatives: Linda Demoranville, Nancy DelPrete, and Vincent Guglielmino.

Present at the hearing were: You (the Appellant) and Agency representative Linda Demoranville.

ISSUE: Is the appellant required to pay a past due Medical Assistance (MA) premium bill of \$129.00?

MCAR RULES AND REGULATIONS: Please see the attached APPENDIX for pertinent excerpts from the Rhode Island Executive Office of Health and Human Services Medicaid Code of Administrative Rules (MCAR).

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:

- Our computer data base (In Rhodes) confirms that she was active on medical assistance.
- She applied on July 12, 2001, and it was granted on August 7, 2001, and it closed on March 31, 2002.
- She was left with a premium of \$129.00 owed. The premium shows as \$43.00 per month for January, February, and March.
- The information line informed the Regional Manager that she (the appellant) had not paid for the months of January, February, and March 2002 and determined that she owed \$43.00 for each month.
- The Agency does not know where the figure is coming from, but could try to research this further to obtain paperwork.
- The Agency is unclear about payment policy at the time.
- The Agency cannot locate any In Rhodes notices which would have included the approvals and denials.
- The billing notices did not come through In Rhodes so they (the Agency) do not have them.
- The Agency located a computer read out which shows that she (the appellant) was requesting MA for her daughter-the premium cost-and not for herself in January, and in February, but not in March 2002.

- None of the readouts show that she was ever receiving the assistance; they show only that she was requesting it.
- Also, the computer read outs show that she received a cost share sanction as of March 31, 2002. There was a past premium due, but the amount does not show, and the months of sanction do not show.
- This last readout helps explain the process as they show that she was on MA, but we are not 100% sure because no notices can be found.

The appellant testified:

- She has a copy of the most recent bill (dated December 2014), and the September bill.
- She has been receiving a bill every month for about 12 years.
- She did not pay any mind to the first bills for so many years, because they only showed a balance of \$0.00 owed.
- She just thought it was a discrepancy from the state and belonged to her youngest daughter.
- After 2002, or in 2003, or in 2004, she got very sick mentally, and didn't take care of any of her bills, and stopped working.
- Over the last year, she began taking care of her bills again, and that's when she noticed she was being billed now for \$129.00.
- She was working in 2002 and her husband had insurance on her and she never needed anything else.
- She did not have any Rite Share or other insurance at the time, so that's why she is questioning it.
- She is still questioning what the Agency is telling her (about coverage for her daughter in 2002) because in 2002 her daughter did not live with her.
- She (the appellant) divorced about 1998/1999, and remarried in 2000, and moved to the current address. Her daughter moved with her only temporarily.
- She never had a need for insurance because she was always working and made good money.

- She was not using any other benefit programs either.
- She had her daughter move out of her home in 2000 or 1999.
- She thinks her daughter was probably applying for herself, but it somehow is showing up on her case.
- Her daughter's date of birth is 1984, and she was 17 at the time. She had her first child in about 2002/2003.
- She thinks her daughter lived on her own since the parents' divorce, and she may have been applying for herself.
- In October of this year when she called the DHS (information) line, the person said they did not understand why she was being charged because she was inactive at that time. They were going to do some research.
- She called again and spoke to someone else, and then again to someone else, and each one told her that she was inactive at that time.
- If she was to get charged for this bill, once this is taken care of, will this bill finally stop?
- The information line also had some information which was inaccurate about her medical information and relationship with another family member who they tied her case into.
- She's wondering if someone was using her information because, when her daughter was about 17 (in 2002) and before she had her child, she got her wallet stolen years ago, and someone used her name and identity to have an abortion, and go to the doctors, and commit a crime.
- There is a police report. She can try and talk to her daughter and get the police report.
- If she had used this, and you (DHS) can show this, and she has to pay this slowly, then she will.
- If she could see a paper trail, and saw her signature on an application, or if she saw a notice when it started and when it ended, she could believe it.
- She wants to know exactly where this is coming from and who applied, and when.

FINDINGS OF FACT:

- A September 12, 2014 monthly premium/cost share premium bill for \$129.00 "balance in arrears" was received by the appellant. It does not include any dates of service.
- Timeliness considerations were granted at hearing on the appeal filed by the appellant on October 27, 2014.
- A hearing was held on January 15, 2015.
- The record of hearing was held open until February 5, 2015 for additional evidence.
- Following the submission of additional evidence from DHS, the held open period was extended until February 13, 2015 to allow a response from the appellant.
- No response was received from the appellant.
- An In Rhodes panel indicates that the appellant asked for MA assistance in January, and February 2002, but not in March. It does not show receipt of MA.
- An In Rhodes panel indicates that on March 31, 2002 the appellant received a sanction for past due MA premiums for a minor parent. She was sanctioned for four months.

CONCLUSION:

The issue to be decided is whether the appellant is required to pay a past due Medical Assistance (MA) premium bill of \$129.00?

The goal of the Rite Care program at the time of the bill was to increase access to primary and preventative care for recipients of the Family Independence Program, as well as to low-income families, pregnant women and children who were underinsured or who did not have access to affordable health coverage. Per MA policy, some MA Rite Care recipients paid a share of their premiums in order to maintain coverage. The premium is determined by coverage groups and countable family income.

The appellant submitted a 2014 copy of a medical monthly premium/cost share premium bill which she has been receiving every month since 2002. She presented that she thought that the original bill had an outstanding balance of \$0.00; and, that she noted more recently that the bill showed a "balance in arrears" of \$129.00. The

appellant argues that she never used the services, and would pay the bill if the Agency could present the paper trail which indicated the bill actually belonged to her.

The Agency presents that an In Rhodes computer read out indicates that the appellant did request coverage in January and February 2002, but not in March. The read out did not clarify whether benefits were actually received. They further testified that a second panel identified that the appellant received a four month sanction on March 31, 2002 for MA premiums past due on a case opened to her for a minor parent. They argue that this sanction showed that the appellant had been receiving benefits, and was being sanctioned for nonpayment of premiums. The panel did not identify which, or how many months, nor did it display the premium amounts. The Agency indicated they had contacted the Information line on the Premium bill and had been told that the appellant incurred a bill for January, February, and March 2002, each for \$43.00 totaling \$129.00. During a held open period which allowed for the Agency to obtain the correlating paperwork to substantiate this claim, they were unable to do so. An email received from the Agency following hearing, indicated that they had obtained that the family's monthly income at the time (\$1597) "would fall under cost share guidelines back in 2002".

The appellant countered that she too had contacted the informational line on several occasions over the past few months, and had been told consistently that she should not have been charged at the time, because she had been inactive. The appellant further testified that the informational line representatives had questioned her about another relative with whom they had paired her information, and she straightened this out. She also contends that she never took out coverage for her daughter, and that her daughter was not living with her in 2002. She testified that possibly her daughter's circumstances-her daughter had been involved in an incident of stolen identity around 2001/2002-were related to the case opening to someone else. Although there were corresponding police reports to substantiate this, these were never presented. The appellant's daughter, born in 1984 was 17 at the time, pregnant with her own child, and not living with her. The mother indicated that she (the appellant) and her husband were both working at the time and they were covered by their own insurance.

The appellant submitted that she would be willing to pay her share if the Agency could show some application, or paper that said she did or did not have coverage. The Agency was able to obtain verbal information that the appellant owed for three months in 2002, but they were unable to obtain any written verification. Additionally, after hearing, they were able to obtain some financial information about the family which suggests that they might have accessed an initial application, but no further verification or explanation was submitted. The Agency further identified that they were unable to obtain any In Rhodes notices after 10 years, though they had been able to access some In Rhodes computer panels with the information previously discussed.

Exploration of appeals policy cites RI General Law with regards to entitlements to reasonable notice for fair hearing. Specifically, the notice must contain "a statement of what action the state...intends to take, the reason for the intended action, the specific regulations that support...and an explanation of the" right to request a hearing. The

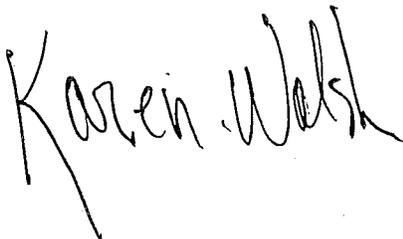
Agency citing the lengthy time between the adverse action and the actual appeal-12 years-was unable to locate any such notices. The appellant testified that she does not believe the bills are correct, and was hoping the notices could shed some light on the course of events. The Agency testified throughout that they could infer some MA use as a result of a sanction in March 2002. However, they could not verify actual use, the amount of premiums, and the month or months being sanctioned. The appellant presented some events in her history which she felt might have confused the issue, and affected the Agency's record keeping.

In summary, the appellant is disputing an ongoing Premium Cost share bill which she receives monthly, and which indicates she is in arrears for a balance of \$129.00. She has been receiving a bill for 12 years. The appellant testified she initially saw the balance as \$0.00, but in later bills saw the balance which now shows. The appellant testified that she had never used MA for herself or her daughter; though an In Rhodes panel notes that she was open to a minor parent (her daughter was pregnant/or had just had a child), and that she was sanctioned for nonpayment of a premium in March 2002. The Agency was unable to locate any notices which developed a paper trail which in turn would have shown the course of events, particularly the dates, and reasons for any closures, the premium amounts, and the months of nonpayment. By law, the appellant has a right to these documents, and without them due process is not served. The record could not establish whether or not the appellant had ever received any lawful notices. Additionally, most likely due to the inordinate amount of time passed; the Agency was unable to develop a clear reckoning of the course of events. As a result, the record of hearing did not establish that the appellant was responsible for premiums incurred in 2002.

After a careful review of the Agency's regulations, as well as the evidence and testimony given, this Appeals Officer finds that the appellant is not responsible for a past due premium cost share bill of \$129.00. The appellant's request for relief is granted.

ACTION FOR THE AGENCY:

The Agency is to rescind the cost share bill, as the appellant is no longer responsible for the past due balance.

A handwritten signature in black ink that reads "Karen Walsh". The signature is written in a cursive, flowing style.

Karen Walsh
Appeals Officer

APPENDIX

MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)

0110.25 LEGAL BASIS FOR APPEALS AND/OR HEARINGS

REV: 08/2013

Procedures are available for applicants and/or recipients who are aggrieved because of a state agency decision or delay in making such a

decision. Entitlements to appeals, reasonable notice and opportunity

for a fair hearing, are provided by:

- o Title 40 of the General Laws of Rhode Island, as amended;
- o Rhode Island Works Program (RIW, as authorized under Title IV-A of the Social Security Act;
- o Medicaid Program, as authorized under Title XIX of the Social Security Act and 42 C.F.R. 431.200 et seq.;
- General Provisions of the OHHS Code of Rules 10
- o Supplemental Security Income (SSI) Program, as authorized under Title XVI of the Social Security Act;
- o Social Services Program, as authorized under Title XX of the Social Security Act;
- o The Vocational Rehabilitation Act of 1972, as amended; and
- o The Food Stamp Act of 1977, as amended.
- o Title 15 of the R.I. General Laws;
- o Chapter 42-7.2 of the Rhode Island General Laws
- o Section 1411 of the ACA and 45 C.F.R. Part 155 Subpart F and section 155.740 of Subpart H;
- o Chapter 42-35 of the Rhode Island General Laws, as amended.

0110.30 DEFINITION OF A HEARING

REV:08/1987

A hearing is an opportunity provided by the agency for responding to

an appeal. It is an instrument by which a dissatisfied individual may

assert his/her right to financial assistance, medical assistance, health insurance, social services, and/or food assistance; and, to secure in an administrative proceeding before an impartial appeals officer, equity of treatment under state law and policy and the agency's standards and procedures.

An opportunity for a hearing is granted to an applicant/recipient or his/her designated representative, when:

- His/Her claim for assistance, social services, or access to a program administered by the RIHBE is denied,
- Is not acted upon with reasonable promptness, or
- S/He is aggrieved by any other agency action resulting in suspension, reduction, discontinuance, or termination of assistance, social services, or access to a program administered by the RIHBE.

A hearing need not be granted:

- If a change in benefits is due to an automatic adjustment required by either state or federal law for classes of recipients, unless the reason for an individual appeal is a challenge of the correctness of the computation of his/her assistance payment or another aspect of the application of the automatic adjustment.

0110.30.05 THE RIGHT TO REQUEST A HEARING

REV: 08/2013

Assistance, social services, child support services and food assistance application forms shall include a statement regarding the right to request a hearing.

General Provisions of the OHHS Code of Rules 11

An individual shall be fully informed of the opportunity for a hearing. At the time of application, and at the time of any action affecting his/her claim for assistance, social services, or health insurance, the individual shall be informed, in writing, of:

- His/Her right to request and receive a hearing;
- The method of obtaining it; and
- His/Her right to be represented by others or to represent himself/herself.

Where applicable, at the time of any action affecting his/her claim for assistance, social services, or health insurance, the individual shall be informed, in writing:

- Of the circumstances under which the applicant's or enrollee's eligibility may be maintained while the appeal is pending; and
- That advance payments of the premium tax credit paid while awaiting a hearing are subject to reconciliation under 26 C.F.R. § 1.36B-4.

A hearing request remains valid until:

- The claimant voluntarily withdraws it and such withdrawal is

confirmed without undue delay by the EOHHS Central Appeals Office in writing (For SNAP benefit hearing requests, upon receipt of a verbal request to withdraw a hearing, the appeals officer shall send written notice within ten (10) days confirming such withdrawal and providing the household with an opportunity to request or reinstate the hearing within ten (10) days of the confirmation notice.); or

- The claimant or his/her representative fails to appear at a scheduled hearing, without good cause (abandonment) as described in section 0110.40 ("Abandonment of the Hearing Request"); or
- A hearing has been held and a decision made.

MEDICAL ASSISTANCE

0348 RITE CARE PROGRAM

0348.05 OVERVIEW OF THE PROGRAM

REV:10/2005

Rite Care is a statewide managed care demonstration project that was established in 1994 under a Title XIX waiver. The project's goal is to increase access to primary and preventative care for recipients of the Family Independence Program (FIP), as well as to low-income families, pregnant women and children who are uninsured or who do not have access to affordable health coverage.

Beneficiaries receiving Medical Assistance through the Rite Care program are enrolled in a health maintenance organization (HMO) which uses a primary care provider to coordinate all medically necessary health care services through an organized delivery system. The Department of Human Services (DHS) contracts with HMOs to provide these health services to members at a capitated rate or fixed cost per enrollee per month.

Under the Rite Care program, expansions in the eligibility criteria for MA are implemented concurrently with a managed care program model of health care delivery. The expanded eligibility is directed at resolving the problems caused by a lack of access to coverage. The managed care delivery system is designed to ensure access to an efficient, organized and available health care delivery system. Section 1931 families (including FIP families), Waiver Families, children under the age of nineteen (19), Katie Beckett children, Adoption Subsidy children, SSI recipients under age twenty one (21), other Medical Assistance Only Families (with the exception of Medically Needy flex-test recipients), and child care providers eligible under the Child Care Provider Rite Care Program may

receive their medical care through the Rite Care managed care delivery system. Families with access to DHS approved Employer-sponsored health insurance plans are evaluated for participation in the Rite Share Premium Assistance Program in accordance with provisions contained in Section 0349. Adults in these families are required to enroll any MA eligible family members in the DHS-approved employer plan as a condition of retaining MA eligibility.

Although Medically Needy flex-test cases may receive services from Rite Care providers, they are paid and delivered on a fee-for-service basis rather than through an HMO. The eligibility rules in this section apply specifically to all pregnant women with countable family incomes not exceeding three hundred fifty percent (350%) of the Federal Poverty Level (FPL), to children under nineteen (19) years of age with countable family incomes not exceeding two hundred fifty percent (250%) of FPL, and to families with children under the age of eighteen (18) with income not exceeding one hundred eighty-five percent (185%) of FPL. The eligibility of other Medical Assistance populations is determined by the rules appropriate to their specific program.

These rules are found in the Rhode Island Department of Human Services Manual, the Medical Assistance Program regulations located in Section 0300 et seq.

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0348.85 MEMBER DISENROLLMENT

REV:01/2002

GENERAL AUTHORITY

DHS has sole authority for disenrolling Rite Care members from health plans, subject to the conditions described in Sections 0348.85.05 and 0348.85.10. The health plan has sole authority for disenrolling members from Related Groups. (See Section 0348.85.25).

Request for disenrollment, either as the result of a formal

grievance filed by the member against the health plan, or by the health plan against the member, is subject to an administrative review process by the Center for Child and Family Health (CCFH). CCFH will decide whether to grant or deny the request based on the circumstances of the individual case.

If, based upon the evidence submitted by the health plan, CCFH determines that the individual should be disenrolled from their current health plan, a notice advising of same shall be sent ten (10) days prior to the date the proposed disenrollment would be effective.

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.