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

Date: February 5, 2015

Docket # 14-2155
Hearing Date: January 2, 2015

[redacted]

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 regulation(s) were the matters before the hearing:

EXECUTICE OFFICE OF HEALTH AND HUMAN SERVICES (EOHHS)
MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)
SECTION: 0348.40.05 PREMIUM SHARE REQUIREMENT

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 Sandra Cipriano, the Agency Supervisor.

Present at the hearing were: You (the Appellant) and Sandra Cipriano, the Agency Supervisor.

ISSUE: Is the Appellant responsible to pay for her Monthly Premium/Cost Share Premium for the month July even though her eligibility ended on the first day of the month?

DHS POLICIES:
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).

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

DISCUSSION OF THE EVIDENCE:

The Agency Representatives testified:

- The agency issued a denial of Medical Assistance to the Appellant on June 20, 2013 due to her not meeting the requirement of being a pregnant woman, a dependent child under the age of 19 or a parent/caretaker relative of an eligible child under the age of 18 whose countable income does not exceed 175% of the FPL, therefore the Appellant's benefits will end July 1, 2013.
- The Appellant filed an Appeal on November 6, 2014 stating that she had received a bill every month since July 2013 for insurance for July 2013 but coverage ended July 1, 2013.
- The agency is unaware of what notice(s) may have issued prior to the June 20, 2013 or what they may have stated.

The Appellant testified:

- The Appellant's family was covered under the State's medical assistance, Monthly Premium/Cost Share Premium program until the end of June 2013. Their monthly premium was $61.00 per month.
- The Appellant received a letter from the agency requesting documents; she submitted those documents pertaining to her family's income and shortly after she received a call from the agency informing her that they would no longer be eligible for benefits.
- The Appellant understood that her family would no longer be eligible for the Cost Share Premium program due to their recent increase of income but was told that it would end at the end of June 2013 and that she would be receiving a notice stating such therefore did not re-apply for the benefit and thought that her coverage would end June 30, 2013.
- Shortly after the telephone conversation with the agency, the Appellant received the June 20, 2013 denial notice informing her that her coverage would end July 1, 2013.
- The Appellant did not use her coverage on July 1, 2013.
- The Appellant is not contesting the benefit ending; she is contesting having to pay for the whole month of July 2013 when she was told that her benefit would end at the end of June 2013 but according to the notice actually ended July 1, 2013.
- The Appellant called the 1-800 Premium Share telephone number, explained her issued and was told that she should file an Appeal.
- The Appellant has question on how she could be sent a notice informing her that her coverage will end July 1, 2013 but be expected to pay a bill for the whole month, not to mention she was verbally told that her coverage would end at the end of June 2013.
- The Appellant has received a bill for $61.00 every month since July 2013.

FINDINGS OF FACT:

- The agency issued a denial of Medical Assistance to the Appellant on June 20, 2013 due to not meeting the requirement of being a pregnant woman, a dependent child under the age of 19 or a parent/caretaker relative of an eligible child under the age of 18 whose countable income does not exceed 175% of the FPL, therefore the Appellant's benefits will end July 1, 2013.
- The Appellant filed an Appeal on November 6, 2014 stating that she had received a bill every month since July 2013 for insurance for July 2013 but coverage ended July 1, 2013.
- The Appellant's family was covered under the State's medical assistance, Monthly Premium/Cost Share Premium program until the end of June 2013. Their monthly premium was $61.00 per month.
- The Appellant received a letter from the agency requesting documents; she submitted those documents pertaining to her family's income and shortly after she received a call from the agency informing her that they would no longer be eligible for benefits.
- The Appellant understood that her family would no longer be eligible for the Cost Share Premium program due to their recent increase of income but was told that it would end at the end of June 2013 and that she would be receiving a notice stating such therefore did not re-apply for the benefit and thought that her coverage would end June 30, 2013.
- Shortly after the telephone conversation with the agency, the Appellant received the June 20, 2013 denial notice informing her that her coverage would end July 1, 2013.
- The Appellant called the 1-800 Premium Share telephone number, explained her issued and was told that she should file an Appeal.
- The Appellant is not contesting the benefit ending; she is contesting having to pay for the whole month of July 2013 when she was told that her benefit would end at the end of June 2013 but according to the notice actually ended July 1, 2013.

CONCLUSION:

The issue to be decided is whether the Appellant is responsible to pay for her Monthly Premium/Cost Share Premium for the month July even though her eligibility ended on the first day of the month?

The agency found the Appellant was no longer eligible for the Cost Share Premium program under Medical Assistance where she was required to pay $61.00 per month for her family of four. The agency was unsure if this new income information of increased income surfaced during recertification or the Appellant's self- reporting. During a telephone conversation that the Appellant had with an agency representative sometime in June 2013, it was explained that the due to the increase of income the Appellant's Medical Assistance case would close by the end of the month but that the agency would

issue a notice stating the Medical Assistance would close. The Appellant fully understood the situation and agreed with her case closing. The agency issued a notice to the Appellant dated June 20, 2013 informing her that her case would be closing but for some reason the notice indicated that the closure date would be July 1, 2013. Since the Appellant is eligible for Medical Assistance for just the first day of July 2013, she is responsible to pay her Cost Share Premium ($61.00) for the month.

Although the agency's notice from June 20, 2013 is closing the Appellant's Medical Assistance case due to her "not meeting the requirement of being a pregnant woman, a dependent child under the age of 19, or a parent/caretaker relative of an eligible child under the age of 18 whose countable income does not exceed 175% of the Federal Poverty Level as of July 1, 2013", (RI DHS Manual § 0328.20), the Appellant is appealing the closure date of July 1, 2013.

The Appellant testified that she was requested by the agency to submit some financial documentation in June 2013 with regards to her household's income. Due to the increase of household income, she already had reason to believe that she would no longer be eligible. The Appellant is not sure as to when but she had a telephone conversation with an agency representative and discussed the increase of income and the closure of her Medical Assistance case. The Appellant testified that the agency representative informed her that due to the increase of income, the Appellant's case would be closing by the end of the month (June) but that the agency will issue a closure notice first. Since the Appellant was not contesting the closure and understood the agency's reasoning, she took the position that she didn't need to do anything else. Shortly thereafter, the Appellant received a notice from the agency dated June 20, 2013 informing her that the Medical Assistance case would be closing, per DHS Manual § 0328.20 and that the closure date is effective July 1, 2013.

As a result of the Appellant's case closing on July 1, 2013, the Appellant received a bill from RI Premium/Cost Share Program for July 2013 for the amount of $61.00. The Appellant made several calls to the agency without receiving a call back. The Appellant also called the 1-800 number that appears on her Monthly Premium/Cost Share Premium and when she explains the issue, she is told that she should file an appeal.

The Appellant's position is she had always compiled with all the requirements asked of her by the agency. When she received a notice requesting financial income, she promptly called the agency and spoke to a representative. The agency representative confirmed the Appellant's believes that since the household income had increased, the Medical Assistance case would be closing. The Appellant specifically recalls being told that her Medical Assistance case would close at the end of the June and that she would be receiving a notice from the agency stating the reason for closure. The Appellant did not argue with the agency representative over this issue due to her already knowing that the increase of income would likely result in losing the benefit and that her family had already make arrangements for healthcare coverage elsewhere that would start in July 2013. The Appellant testified that she was given the impression that she didn't need to do anything and that her case would naturally close at the end of June 2013. The

Appellant received a notice dated June 20, 2013 from the agency informing her that her Medical Assistance case would be closing, just as she had been told but the notice indicated that the closure date was July 1, 2013. The Appellant testified that she was confused and thought that maybe her Medical Assistance case would closed June 30, 2013 at 11:59 p.m. and effective July 1, 2013 at 12 a.m. she no longer would have coverage.

Regardless, the Appellant did not to anything until she started to receive a $61.00 bill for her Monthly Premium/Cost Share Premium. The Appellant testified that she called the agency to find out what time frame that this bill was for since she had always paid her bills and was never late but she had never received a call back from the agency. The Appellant resorted to calling the 1-800 telephone number that appears on her Monthly Premium/Cost Share Premium bill and was instructed to file an appeal.

Since the Appellant is not appealing the reasoning behind her Medical Assistance case closing and is in agreement with the reasoning that is stated in the June 20, 2013 notice; the Appellant is appealing the closure date itself. There was no disputed testimony that the Appellant had submitted financial information to the agency; that the Appellant had a telephone conversation with an agency representative that inform the Appellant that since she was over income, that her Medical Assistance would be closing at the end of June 2013; or that a closure notice dated June 20, 2013 had issued to the Appellant by the agency informing her that her case would be closing on July 1, 2013.

The agency policy specifically states with regards to Premium Share in § 0348.40.05 states in part that:

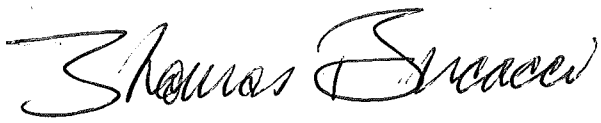
> Monthly premiums are not prorated. Therefore, a full monthly premium is due if the family receives MA coverage for any portion of a coverage month.

Therefore, since the Appellant's eligibility for the Medical Assistance - Monthly Premium/Cost Share Premium program closes on July 1, 2013 the Appellant is responsible for that months premium of $61.00. The Appellant having read the June 20, 2013 notice, could have and should have contacted the agency to ensure that her case closed on June 30, 2013.

In summary, the Appellant provided the agency with new income information that once the agency reviewed was used to determine that the Appellant was no longer eligible to participate in the Medical Assistance – Monthly Premium/Cost Share Premium which required her to pay $61.00 per month. The Appellant and an agency representative had a telephone conversation where it was explained to the Appellant that due to the increase of income, she would no longer be eligible for the Medical Assistance – Monthly Premium/Cost Share Premium program and that her case would close by the end of the month but a notice will be mailed to the Appellant stating this first. The Appellant received this agency notice dated June 20, 2013 which did state that the Appellant would be losing her Medical Assistance but that it would end on July 1, 2013

not at the end of June 2013 as the Appellant was told on the telephone. By adding that one extra day, allows the case to be open in a new month for just one day and exposed the Appellant to a $61.00 bill for the month of full month of July 2013.

After a careful review of the Agency's policies, as well as the evidence and testimony given, this Appeals Officer finds that the Appellant is responsible to pay for her Monthly Premium/Cost Share Premium for the month July. The appellant's request for relief is therefore denied.



Appeals Officer

APPENDIX

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES

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.

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.