Rhode Island Executive Office of Health and Human Services
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March 31, 2015

Hearing Date 03-2-15
Docket # 14-2430

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 policy reference(s) were the matters before the hearing:

THE DHS POLICY MANUAL: **Medical Assistance**
Section: 0348.40.05 Premium Share Requirements

The facts in 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: Cheryl Trembley and Denise Tatro.

Present at the hearing were you and Agency representative: Cheryl Trembley.

ISSUE: Should the appellant have to pay cost share balance of $184.00?

DHS POLICIES: Please see the attached **Appendix** for pertinent excerpts from the 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 appellant was Active on Rite Care in December 2012.
- She had to pay a Premium payment of $92.00 a month.
- The Agency has no record of the appellant asking for her case to be closed.
- The appellant's case did close in March 2013 for non -payment of premium.
- The Agency sent a notice on March 18, 2013 advising the appellant of this.
- The premiums were not paid and the case closed on March, 31, 2013.

The appellant testified:

- She was on Rite Care in December 2012.
- She got a new job which gave her employer health insurance.
- She got a letter that said she was eligible to enroll in Rite Share in December 2012.
- She knew she had insurance through her employer and the Human Resources at her employer faxed this notice to DHS.
- She called to ask that her Rite-Care case be closed.
- She believed that her company had faxed the notice to DHS.
- She thought her Rite-Care case was closed.

Findings of fact:

- The appellant was active on Rite-Care in December 2012.
- The appellant did change her job.
- The appellant was receiving employer sponsored health insurance in January 2013.
- The appellant's Rite-Care case remained active at this time.
- The appellant was sent a notice on January 2, 2013 that her Rite-Care case remained open and she had a premium payment of $92.00 a month.

- The Agency sent a notice on March 18, 2013 that the appellant needed to pay her premiums by March 31, 2013 or her case would close.
- The premiums were not paid and the case closed.
- The appellant continued to receive a bill for the amount of $184.00 and filed an Appeal.
- The hearing was held on March 2, 2015.
- The record of hearing was held open for further evidence.
- New evidence was received before the record closed.

The issue to be decided is whether the appellant owes the premium payments of $184.00 for the Months of February and March 2013.

A review of Agency Policy reveals that some Rite Care participants pay for a portion of the cost of their health care coverage by paying a monthly premium and/or co-payments for certain services. The purpose of cost sharing is to promote more efficient and cost effective utilization of services and to encourage program participants to assume some financial responsibility for their own health care. Program participants who fail to make required cost-sharing contributions may be denied a service or continuous Medical Assistance coverage in certain circumstances.

In this case the Agency provided a Notice dated January 2, 2013 indicating the appellant was not eligible for Rite Care; however her child was and she had a $92.00 premium each month. The appellant testified that she notified the Agency that she was eligible for employer sponsored insurance and that was why she did not pay the premiums due for February and March 2013.

The Agency testified that they had no record of the appellant asking that her case be closed. The appellant testified that she called the Agency. She did not make a written request. The appellant testified that she received a letter from the Rite Share office on December 18, 2012 advising her that she must enroll in employer sponsored insurance by January 1, 2013 for her child to remain on Medical Assistance. The notice further stated that her employer sponsored insurance should begin on February 1, 2013 and that her child would remain on Rite Care until that time. This verifies that the appellant knew she was still covered by Rite Care at least until February 1, 2013. On January 23, 2013 the appellant was notified that she was not eligible for the Rite Share Program as the rates quote her employer sent to the Agency was incorrect. The appellant was aware at this time that she was not Rite Share eligible and had been sent a notice on January 2, 2013 that her Rite Care eligibility remained and she continued to have a $92.00 premium payment. The appellant was sent another notice on March 18, 2013 indicating that she owed premiums for the months of February and March 2013 and if they were not received by March 31, 2013 her case would close.

There is no record that the appellant contacted the Agency at that time and stated that she had requested her case be closed and that she felt she did not owe these premiums. The next time the Agency hear from the appellant was in December 2014 when she requested a hearing.

The preponderance of evidence is that the Agency kept the appellant's Rite Care case open appropriately until she did not pay her premiums and there is no evidence of her request that it be closed; therefore her request for relief is denied.

Geralyn B. Stanford
Appeals Officer

APPENDIX

0348.40.05 Some Rite Care participants pay for a portion of the cost of their health care coverage by paying a monthly premium and/or co-payments for certain services. The purpose of cost sharing is to promote more efficient and cost effective utilization of services and to encourage program participants to assume some financial responsibility for their own health care. Program participants who fail to make required cost-sharing contributions may be denied a service or continuous Medical Assistance coverage in certain circumstances. However, non-payment of cost- sharing for emergency care, urgent care, or pregnancy related services shall not prohibit access to necessary care or affect enrollment status of eligible Title XIX Rite Care Health Plan members.

Premium Share Requirements

The following individuals/groups must pay a monthly premium to maintain coverage.

- MA Waiver Families with income equal to or greater than one hundred

thirty-three percent (133%) of the federal poverty income guidelines (FPL) and not exceeding one hundred seventy-five percent (175%) of FPL

8. Children age one (1) to nineteen (19) with family income equal to or greater than one hundred thirty-three percent (133%) of FPL and not exceeding two hundred fifty percent (250%) of FPL

9. Pregnant Women with family income above two hundred fifty percent (250%) of FPL and not exceeding three hundred fifty percent (350%) of 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.

10. Extended Family Planning recipients with family income above two hundred fifty percent (250%) of FPL and not exceeding three hundred fifty percent (350%) of 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 Monthly premiums are not prorated. That is, a full Monthly premium is due if the family receives MA coverage for any portion of a coverage month.

0348.40.05.05 Non-Payment of Premiums

REV: 10/2009

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:

2. 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 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.

3. A re-applicant is treated like a current recipient.

4. 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.

5. 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.

6. 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.)

7. 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

8. the coverage month. (If payment due on 1/1 is not received by 2/12, MA eligibility is discontinued effective 2/28.)
9. Dishonored checks and incomplete electronic fund transfers are treated as non-payments.
10. 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

11. 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

12. 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 dis-enrolled 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.

CHANGES IN COST SHARING STATUS

Medical Assistance recipients are required to report any changes, such as changes in income or family composition, which could affect the family's cost sharing status or premium share, within ten (10) days.

When such as 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.

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.

2. 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.

The individual or family pays the premium to DHS by check or money order every month. A premium payment coupon and pre-addressed envelope will be provided to the family before the premium is due. The check or money order and the premium payment coupon are mailed or delivered to the DHS fiscal agent. The recipient may choose to pay by Debit/Credit card or electronic check by phone or internet. Cash payments are also accepted at locations in the community

The medical provider is responsible for collecting copayments at the point-of-services delivery. The health plan must not bill or attempt to collect any fee from, or for, a Rite Care member, except for the cost sharing amounts required.

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.