STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
APPEALS OFFICE - LP Bldg.
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Docket # 14-295
Hearing Date: May 13, 2014

Date: June 4, 2014

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:

RHODE ISLAND POLICY MANUAL (HSRI MANUAL)
Chapter IX: INDIVIDUAL ELIGIBILITY AND SHOP APPEALS
B. Appeals Process Rules, 1-Notice of Appeal Rights

Chapter IV: ELIGIBILITY FOR ADVANCED PREMIUM TAX CREDITS AND COST SHARING REDUCTIONS
B. APTC Eligibility, 4-Ineligibility Based on Access to Minimum Essential Coverage, b) Government sponsored MEC

POLICY MANUAL: EXECUTIVE OFFICES OF HEALTH & HUMAN SERVICES
Access to Medicaid Coverage Under the Affordable Care Act
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), DHS Agency representatives: Fina Cicerchia, Kristen Grosso, Betty Perez, HSRI representative Lindsay Lang, and the Policy Unit.

Present at the hearing were: You, Agency representatives: Kristen Grosso, and Fina Cicerchia.

ISSUE: Was the appellant accurately assessed for medical coverage eligibility?

DHS POLICIES:
Please see the attached APPENDIX for pertinent excerpts from the Rhode Island Executive Office of Health &Human Services, Access to Medicaid Coverage Under the Affordable Care Act, and the Rhode Island Policy Manual (HSRI 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 applicant applied for Medicaid coverage through the UHIP/Health Source system, and was initially found eligible.
- The error in enrolling her was discovered, and she received notice that her eligibility would end because under the MAGI rules, she is not eligible.
- If you're enrolled in Medicare or have access to Medicare, you are not eligible through the Exchange. She is enrolled in Part A, and has opted out of Part B.
- The notice says she is not eligible for Medicaid, meaning MAGI Medicaid through the Health Source system.
- If she applied for Medicaid as a disabled adult through a DHS-2 she might be found eligible for Medicaid.
- We are aware that she gets disability insurance.

- We have met and discussed with her that she might be able to do a medical spend down towards a Flex plan. They will look at income, and guidelines to make a determination.

- She will need to pay some bills to get below income level to meet the spend down.

- If she applies today and is found eligible she cannot go back to the January 16th date.

- She is not eligible for Health Source because she is enrolled in a Medicare plan, and it is unclear if she is eligible for Medicaid because she never applied.

- She would have to contact Social Security to determine what the cost of Medicare would be now. She could use this premium as part of her Flex plan if found eligible.

- It appears that there might have been a DHS application denied on April 4th, but it can't be determined what happened.

The appellant testified:

- She is on disability and receives $1200 per month, and could not afford Part B of Medicare.

- 90% of her money goes towards the mortgage and the rest goes to everything else.

- She receives SSDI for total disability.

- Lifespan has been telling her different information about the spend down than she is hearing today from DHS.

- She had hoped to keep some money as a nest egg, but is now hearing she must spend it to get services.

- She doesn't have good comprehension and needs to know how to get it (medical insurance).

- She thought she could have the Obama care, and didn't understand all this.

FINDINGS OF FACT:

- An Eligibility Decision notice dated January 16, 2014, informed the appellant that she was not eligible to purchase health insurance through Health Source RI because she was enrolled in a Medicare plan and not eligible for Medicaid.
- The appellant submitted a timely request for hearing dated February 3, 2014.
- The appellant receives SSDI benefits totaling $1298.40 monthly.
- The appellant has Medicare Part A coverage and does not have Part B coverage.

CONCLUSION:

The issue to be decided is whether the appellant's medical coverage eligibility was accurately assessed in January 2014.

The Agency presented that the appellant appeared to have been denied medical coverage through the UHIP system as a result of her enrollment in, or access to, Medicare. She was receiving Medicare Part A and had chosen not to receive Medicare Part B. They argued that Health Source policy does not allow insurance to be extended to applicants who already have access to Medicare coverage. The Agency identified that the notice stated that the appellant was not eligible for Medicaid, but this most likely referred to MAGI (modified adjusted gross income) Medicaid. She could possibly be eligible for Medicaid based upon her disability. They indicated they had spoken with the appellant prior to hearing, and she would have to be willing to work through a flex spending plan if found eligible. They added that the appellant was still able to apply for Medicare Part B.

HSRI representatives were not present at the hearing to support the Medicaid finding.

The appellant argues that she applied through Health Source Rhode Island (HSRI) for medical coverage. She now wants "new eligibility" as she was told she was ineligible for Obama care and ineligible for Medicaid. To date, she had had some discussions with DHS and had not wanted to eliminate her savings in order to participate in either Medicare Part B, or in Medicaid.

There is no dispute that the appellant was not eligible to purchase health insurance through Health Source Rhode Island (HSRI) if she was receiving Medicare benefits. A review of policy indicates that the appellant would be ineligible for HSRI coverage if she

was receiving, or had access to, benefits. In this case, the appellant had access to Medicare Part B, and had refused it.

There is some confusion however, as to whether or not the notice was referring to MAGI (modified adjusted gross income) Medicaid groups or Non-MAGI coverage groups (include persons aged, blind or with disabilities…) when identifying the appellant was ineligible for Medicaid. The Agency indicated the appellant would need to fill out a DHS-2 application to determine eligibility. As a result of "no wrong door" policy, the appellant's application for Medicaid should have been assessed and processed regardless of how and where she applied.

It is also unclear as to how the Medicaid determination was made as the notice did not support its' decision by citing any sources of law, policy, or regulation. Policy indicates that decisions must be supported with reasons for taking the action, and by identification of the law or regulations which support the action taken. This did not occur.

In conclusion, the appellant was informed on January 16th that she was ineligible for insurance through Health Source Rhode Island (HSRI) citing the reasons-enrolled in a Medicare plan and not eligible for Medicaid. Per policy, the appellant was ineligible for HSRI as she had access to Medicare. However, the omission in the notice failing to inform the appellant of reasons for her Medicaid denial violated her legal rights as well. Due to her disability status, it is probable she may be eligible for some Medicaid services. Thus, the second part of the notice was most likely wrong.

In summary, the appellant was correctly disqualified for HSRI coverage based upon her Medicare status. However, she was not afforded due process with respect to her Medicaid denial, as a result of an incorrect notice. Thus, this appeals officer finds for the appellant.

After a careful review of the Agency's policies, as well as all the evidence and testimony given, this Appeals Officer finds that the appellant was incorrectly assessed for medical coverage eligibility. The appellant's request for relief is granted.

ACTION FOR THE AGENCY:

The DHS Agency is to assess the appellant for the possibility of Medicaid coverage as of January 16, 2014. This action is to be completed by June 16, 2014.

Pursuant to DHS Policy General Provisions section 0110.60.05, action required by this decision, and completed by the Agency representative must be confirmed in writing to this Hearing Officer.

Karen E. Walsh
Appeals Officer