STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
APPEALS OFFICE - LP Bldg.
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Date: June 9, 2014

Docket # 14-514
Hearing Date: May 5, 2014

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
SECTION 0348.40.05.05 Non-Payments or Premiums
SECTION 0349.05.05 Scope of Rite
SECTION 0349.05.10.05 Rite Share Enrollment as a Condition of Eligibility

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 Agency representatives: Judith Anderson, Nancy DelPrete.

Present at the hearing were: You, and Agency representative Judith Anderson.

ISSUE: Is appellant required to pay a past due Medical Assistance (MA) bill of $122.00?

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:

- She (the appellant) received the notice saying she owed the $122.00, and the case closed because she did not pay the premium, not because she voluntarily withdrew from the medical.
- She received a March (2013) notice stating she would have a premium because she was over income.
- She (the appellant) came in on the 5th of May (2013), and there was no indication she wanted closure but she was dissatisfied with the payment owed.
- At that time, there was no dispute about having to pay a premium. She added her employer insurance to the case as the primary insurer.
- Another complication was that she had been living in Massachusetts (Ma.), and it appeared she was covered under Ma. Medical, so a Paris match was sent out to the appellant to verify documentation especially residency.
- A Paris match is used to determine if you are getting coverage from two states. It was sent on June 6th requesting documentation, but no response was received by DHS.
- She says now that her roommate possibly took her mail.
- DHS does now have verification that she did not use any services for the time period which she is disputing.

- Our Agency would have tried to reconcile this bill, and have the client absolved from owing the $122.00 if we could have had any verification that she had requested to have her case closed.

- There is nothing in the CLOG besides the May 5th office appointment and it does not note her asking for closure.

- The number given to the appellant by the DHS worker in May 2013 is the payment part of Rite Share. They have no other jurisdiction.

- A worker spoke with the client on February 1, 2014; sent her a hearing request form on Feb.21, 2014; and, it was returned on March 13, 2014 when she came into the office.

- She is now saying that she was happy her case closed, but was not aware she would continue to receive bills.

- The notice sent to her on March 20, 2013 for medical insurance approval, stated she would have a bill.

The appellant testified:

- In May (2013) she came in for help paying her current premium that she was getting through her job.

- She was told there were two different departments, and she would have to qualify through here (DHS) and then would have to petition to qualify for premium assistance through the other program.

- She was given a fax number to fax over information.

- She faxed all her information, but she never got anyone on the phone there to confirm. She needed to fax her information to Rite Share.

- The worker also told her to either pay the current $61.00 premium, and fight for reimbursement once she got onto the other premium share program; or, if she decided she didn't want the insurance, don't pay it, the case would be closed.

- The worker told her to go with the state insurance or get it through her job.

- Shortly afterwards, she decided she didn't want the insurance because she was doing fine paying insurance herself through her job, and she got a pay raise at her job.

- When she got the notice her case was closed, she was happy because she didn't want that insurance anyways because she was getting it through her job and she hadn't gotten any help, just more bills.

- Following the denial, she kept trying to call and figure out how to stop these bills. She called everyone-the worker, numbers on the bills, numbers on the health cards.

- Collections told her they were just collections and could not stop the bills from coming.

- She couldn't get through. She left the worker 100 messages and never got a call back. She has been calling since last June 2013.

- Finally, one month ago, a worker (DHS) returned her call and said she could appeal, but should have appealed one year ago. Not one person told her she could appeal.

- The notice did say she could appeal but she didn't want to appeal the case closing-she wanted to appeal the bill.

- She got some United Health cards after March 2013, and she contacted them (United Health) to say she didn't want their insurance.

- United told her to call them (DHS) if she didn't want it, so that's when she started to call, and when she came in in May.

- She was not disputing the insurance at the time but trying to find out why things were so different from Massachusetts.

- After the case was closed, she decided she would not fight it, but just keep her regular insurance.

- She could not figure out how to leave a message.

- Maybe they (DHS) didn't call back because now the message says you are supposed to leave your social security number and she never left her social security number.

- She could never get anyone to call her back.

- She continued to receive bills, and had thought the case closed back in 2013.

- She told the worker in May (2013) she didn't want a bill, she wanted help. She told him "get me off this, or close my account."

- She never used anything all that time and no one ever returned her calls until the worker called her back in February (2014).

- She doesn't think she ever came into the office again to discuss this.

- She did realize they (DHS) would want payment because the notice said your case was closed but you owe $61.00 for this month and $61.00 for that month.

- That's when she tried to call to say she never used this, and never wanted it. The first bill came right after it closed-in July, and she has been getting them every month since.

- She has no paper trail or evidence of her phone calls.

FINDINGS OF FACT:

- The appellant received a notice dated March 20, 2013 which informed her she was eligible for Medical assistance (MA) which had begun on March 1st, and that she would have to pay a monthly family premium of $61.00, beginning in May.

- The appellant was notified per a notice dated June 17, 2013 that her eligibility would end on June 30, 2013 for nonpayment of the premiums for the months of May and June. It read further that if payment was received by June 30th, and she was otherwise eligible, there would be no ineligibility period.

- The appellant has continued to receive an MA family premium bill in the amount of $122.00 every month since closure.

- The appellant filed a request for a hearing, received by the Agency on March 13, 2014.

CONCLUSION:

The issue to be decided is whether the appellant is required to pay a past due Medical Assistance (MA) family premium bill of $122.

There is no dispute that the appellant applied for Medical Assistance (MA) in March 2013. A notice dated March 20, 2013 informed her of the following-eligibility beginning on March 1st; her cost share premium payments of $61.00 per month; and, her responsibility to pay her first premium in May. Per MA policy, some MA Rite Care recipients must pay a share of their premiums in order to maintain coverage. This premium is determined by coverage groups and countable family income. Additionally, a full monthly premium is due if the family received MA coverage for any portion of a coverage month. There is also agreement that the appellant never used her MA health coverage.

The appellant argues that she came into the office in May 2013, after the notice of eligibility and prior to her case closure for nonpayment. In her testimony initially she agreed that she was not looking for case closure, but assistance with paying her premium. She brought in a health card received in the mail, and questioned the covering worker as to why the regulations were so different in Rhode Island than in Massachusetts. He informed her there were two programs and she would need DHS acceptance first, and then she would need to be accepted into the premium program. She states she was referred to a Rite Care information line in order to fax her information, which she did. It is unclear if she was being asked to submit employment information so that Rite Share accessibility could be assessed as well. She never received any confirmation or any call back from that source. The worker informed her as well, that she should accept either state coverage or employer coverage. She should pay the current premium and fight for reimbursement later if she was accepted into the other program, or if she didn't want the insurance and she did not pay the premium her case would close. In later testimony she indicated she told the worker to get her help or close the case.

The Agency contends that the appellant did come into the office in early May 2013, and according to the CLOG, there was no discussion about closing the case. She had brought in her employer information to the worker, and was questioning the cost of the premium. The Agency identified that the phone number the appellant was submitting at hearing, was a Rite Care/Rite Share informational number which could have assisted the appellant with billing accessibility. This was never clarified as the appellant faxed her information to someone, and was unable to confirm who or where or why as she never had any follow up discussions. MA policy indicates that Rite Share application could be made with initial eligibility applications, or as a result of participation in an individual's employer in Rite Share, or in coordination with a determination of whether or not an employee sanctioned insurance was cost effective. The Agency added that the

employee information would have allowed the employer to be determined as primary coverage and the state as secondary.

The Agency testified as well that there were further complications in that there was some question as to whether the appellant was also receiving Massachusetts coverage at the same time. To clarify this, DHS sent out a request for residence verification to the appellant's home to obtain further documentation. They never received any verifying information. The appellant recently told them that her neighbor may have taken her mail.

The Agency further argued that the appellant had already received her first notice of eligibility informing her of her receipt of coverage which began on March 1st, and for which she would be billed in May. They questioned why, upon receipt of the closure notice, she chose not to appeal, and as the notice also indicated that she had incurred an outstanding bill.

The appellant countered that sometime in May she no longer needed her MA coverage and she was relieved when she received the closure notice as she did not want it anyways. She testified that she did not appeal at the time because she understood she would be appealing the case closure but not the bill. She later testified she was aware that she had an outstanding bill, according to the notice. The appellant continued to receive bills from July 2013 to the present, for the months of May and June totaling $122.00. She began to call the Agency, the collections agency, and the health coverage provider. The collections agency told her they could not stop the bill as it was not their responsibility. She made over 100 calls and never received a response until February 2014, at which time she was informed she could appeal the bill-which she did.

A review of MA policy indicates that DHS incurs a monthly cost for each month a recipient has access to coverage whether or not it is used. Additionally, a full month is billed if the member had access to even one day's coverage. The appellant entered the DHS office in early May of 2013. According to MA policy she had already incurred the bill for the month of May. Her testimony was somewhat conflicting and ambiguous as to whether or not she tried to inform the worker at that time to close her case. The one year lapse of time between the actual circumstances and the present may account for some discrepancies of memory. At best, the appellant cited that she told the worker to get her help or close her case. She also testified that the worker told her to continue to pay the premium until further assistance could be determined. There is no note in the record which indicates the word closure, and according to policy it was already too late to forego the first bill. However, the record shows no discussion or dispute that the appellant was unwilling to pay this first premium-lending some credibility to the Agency premise that she wasn't asking to close. Additionally, if the appellant had formally asked for closure, she would have avoided the additional bill for $61.00 for the month of June which she was already aware would be charged to her. It is further supposed that the Agency would not have denied her closure if they clearly understood she wanted closure. This in turn supports the Agency testimony that the appellant came into the

office to present her employer information and discuss the premium, not to close the case. The appellant testified that she never used the insurance, and evidence supports this fact. She stated she never wanted the insurance, and never got any help-only bills. It is unclear if she understood she had coverage from the time of application in March, or whether her other coverage sufficed and she did not need it. However, the initial notice clearly identified the coverage periods, premium costs, and billing dates. Evidence and testimony indicates that the appellant did not dispute this at the time of her one and only appointment with DHS, nor did she diligently pursue clarity, or appeal the decision in June when she received the notice of closure and the statement of the monies owed.

The appellant identified that she attempted to contact the Agency 100 times over the past year, with no response. Though, this number was assumed to be anecdotal in nature, the appellant was trying to illustrate that she attempted to ask for help ongoing. The Agency does not dispute the possibility of this, but the evidence on record shows only one visit to the DHS office and no contact until February 2014. The appellant was unable to corroborate her testimony with any paper trail. She added that perhaps no return calls were made because she never left her social security number as requested, until recently, for security reasons. She also suggested that she had not responded to DHS residency inquiries in June 2013 because at one point her neighbor had perhaps been taking her mail. At the same time, the appellant testified that she had been getting bills to the same address since July 2013, and she had received the March 2013 notice and the June notice to the same address. The appellant had further testified that she had not returned to the DHS office or followed up with any letters or other correspondences in order to clarify the bill. She testified that for the past year she has been upset by the ongoing receipt of the bills, and the calls to her home which continue to this day from a collections agency. However, she reports no other attempts such as direct correspondence or office visits to rectify the situation.

In conclusion, the appellant received notice in March 2013 of her eligibility, her coverage period begun that month, and of the expectation in May of payment of the first premium. In May she visited the DHS office and produced her employer insurance information, and questioned the premium payments. Credible evidence and testimony supports the Agency's argument in that the appellant did not ask for closure at that time, nor did she refute payment of the first bill she was to receive in May. Per policy, DHS had already incurred expenses for the coverage extended to the appellant, and regardless of a request for closure or not, on that day, she would still have had to pay for that first month of coverage. Testimony does not support the appellant's claims that she diligently pursued clarity of her medical status, nor did she appeal the decision in June 2013 when she received the notice of closure. She testified that she understood when she received the notice that she had an outstanding bill of $122.00. Policy indicates that the recipient is responsible for the cost of premiums for the months in

which she was billed, regardless of her use of the coverage. The appellant indicated she never used the coverage, but is never-the-less, responsible for the bills incurred.

After a careful review of the Agency's policy, as well as the evidence and testimony provided, the Appeals Officer finds that the appellant is required to pay the cost share premiums totaling $122.00 for the MA coverage received for the months of May and June 2013. The appellant's request for relief is denied.

Karen E. Walsh
Appeals Officer