



Date: May 14, 2015

Docket # 14-2132

Hearing Date: April 13, 2015



ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been REMANDED back to the agency, HSRI. 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)

RULES AND REGULATIONS PERTAINING TO THE RHODE ISLAND HEALTH BENEFITS EXCHANGE § 12.2 PAYMENT TO THE TRUST

RHODE ISLAND POLICY MANUAL - CHAPTER 12 – TERMINATION, BILLING AND LATE PAYMENTS

The facts of your case, the Agency regulation(s) 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 Noah Zimmerman, Esq., Lindsay Lang, Esq., and David Dee, Esq. representatives from HealthSource RI.

Present at the hearing were: You (the Appellant) and Noah Zimmerman, representative from HealthSource RI.

ISSUE: Is the Appellant responsible to pay for the balance of her 2014 premiums for healthcare?

EOHHS 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).

APPEAL RIGHTS:

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

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).

DISCUSSION OF THE EVIDENCE:

The HealthSource RI Representatives testified:

- HealthSource RI (HSRI) issued a "Medicaid Termination Notice" on April 12, 2014 stating that the termination is due to the Appellant not being eligible due to her household income is greater than Medicaid requirements for adults without dependent children.
- HSRI presented a screen-shot/printout from the HSRI computer system (UHIP) that indicates that the Appellant changed her income \$2900 per month for 2014 that is coming from a pension on April 11, 2014. The Appellant's income was adjusted again on November 16, 2014 as being \$34,800 per year.
- This screen shot also indicates that the change was done by the Appellant since it has the "Username" and not UHIP.

The Appellant testified:

- The Appellant is not receiving Medicaid and has never received Medicaid.
- She had previously had healthcare coverage through HSRI but in October/November 2014 when she was informed by HSRI that she does not have coverage. Furthermore, any payments that she has been sending in, has been applied to her over- due premium payments.
- The Appellant selected a healthcare policy for 2015 and a payment was made in December 2014 but it had been applied to the Appellant's outstanding balance for 2014 by HSRI. When the Appellant called HSRI and spoke with a representative (Lesley) and was told not to make any more payments until this issue is fixed.

- The only form of income is from social security in the amount of \$1490.00 per month and from Aetna Insurance in the amount of \$1561.11 per month (\$3051.11 per month/\$36613.32 annually).
- The Appellant presented a copy of her 1040 individual income tax return for 2014 that reflects that the Appellant had an adjusted gross income of \$28,927.00.
- The Appellant was originally informed that she needed to pay \$254.00 per month for healthcare premiums and made those payments. After a few months of paying \$254.00 she received a notice that she need to pay \$386.00 and then another moth was told her premium was \$336.00 per month for the same plan. The Appellant called HSRI and was informed that the problem was just a computer glitch and that she should continue to pay the \$254.00 and without her knowledge, she was falling further and further behind in her payments.
- According to the bills from HSRI, the Appellant has an outstanding balance for 2014 in the amount of \$723.16 as a result of not paying the monthly premiums in full.
- As a result of being told by a HSRI representative to stop making payments towards the Appellant's 2015 healthcare plan since any payment was being applied to the Appellant's 2014 balance, she currently has no healthcare coverage for 2015.

The record of Hearing was kept open two week until April 27, 2015 to allow HSRI to recalculate the Appellant's income, using the figures that were submitted to the IRS as part of the Appellant's 2014 income tax filing.

FINDINGS OF FACT:

- HealthSource RI (HSRI) issued a "Medicaid Termination Notice" on April 12, 2014 stating that the termination is due to the Appellant not being eligible due to her household income is greater that Medicaid requirements for adults without dependent children.
- HSRI presented a screen-shot/printout from the HSRI computer system (UHIP) that indicates that the Appellant changed her income \$2900 per month for 2014 that is coming from a pension on April 11, 2014. The Appellant's income was adjusted again on November 16, 2014 as being \$34,800 per year
- This screen shot also indicates that the change was done by the Appellant since it has the "Username" and not UHIP.
- The Appellant was originally informed that she needed to pay \$254.00 per month for healthcare premiums and made those payments. After a few months of paying \$254.00 she received a notice that she need to pay \$386.00 and then another moth was told her premium was \$336.00 per month for the same plan. The Appellant called HSRI and was informed that the problem was just a computer glitch and that she should continue to pay the \$254.00 and without her knowledge, she was falling further and further behind in her payments.

- She had previously had healthcare coverage through HSRI but in October/November 2014 when she was informed by HSRI that she does not have coverage. Furthermore, any payments that she has been sending in, has been applied to her over- due premium payments.
- The Appellant selected a healthcare policy for 2015 and a payment was made in December 2014 but it had been applied to the Appellant's outstanding balance for 2014 by HSRI. When the Appellant called HSRI and spoke with a representative (Lesley) and was told not to make any more payments until this issue is fixed.
- The only form of income is from social security in the amount of \$1490.00 per month and from Aetna Insurance in the amount of \$1561.11 per month (\$3051.11 per month/\$36613.32 annually).
- The Appellant presented a copy of her 1040 individual income tax return for 2014 that reflects that the Appellant had an adjusted gross income of \$28,927.00.
- According to the bills from HSRI, the Appellant has an outstanding balance for 2014 in the amount of \$723.16 as a result of not paying the monthly premiums in full.
- As a result of being told by a HSRI representative to stop making payments towards the Appellant's 2015 healthcare plan since any payment was being applied to the Appellant's 2014 balance, she currently has no healthcare coverage for 2015.

As of the close of business on April 27, 2015, the agency failed to submit the recalculation of the Appellant's income from her 2014 IRS filing.

CONCLUSION:

The issue to be decided is whether the Appellant responsible to pay for the balance of her 2014 premiums for healthcare?

The Appellant applied for and was found eligible for a Qualified Health Plan (QPH) with Advance Premium Tax Credits (APTC) to help off-set the cost of the monthly premiums at the beginning of 2014. On April 11, 2014, although the Appellant denies entering onto the HSRI computer system and changed her household income, changes were made with the use of her "username". The HSRI representative testified that due to this change of household income amount, which increased from what originally was imputed for household income, causing the amount of APTC to decrease and the amount of the monthly premium that the Appellant pays to increase. HSRI did not submit evidence or testimony as to what the Appellant's household income was originally, only that the income has changed.

On April 12, 2014 HSRI issued a "Medicaid Termination Notice" which stated that the Appellant is not eligible for Medicaid because her household income is greater than Medicaid requirements for adults without dependent children. The Appellant testified that the reason that she didn't appeal this April 12, 2014 Notice was due to the fact that she was not receiving Medicaid and never had received Medicaid.

The Appellant testified that in November or possibly as early as October, she had contacted HSRI as to why she is receiving bills for different amounts other than \$254.00 per month. The Appellant stated that she had first been told that there was a glitch in the computer system and to continue making her regular payments. When she called HSRI again, she was told that she had lost her coverage due to partial payments and that she had an outstanding balance. When it was open enrollment time for healthcare sign-ups for 2015, the Appellant completed her application and made a payment for January 2015. Unfortunately, the payment that was made by the Appellant for January 2015 was applied to the Appellant's 2014 HSRI balance. When the Appellant brought this issue to HSRI, she was told to stop making any future payments and as a result the Appellant presently has no healthcare coverage. It is believed that there is a \$723.16 balance that the Appellant still owes HSRI for premiums for 2014.

The agency failed to testify or present evidence during the hearing as to when the increase cost of the Appellant premium went into effect but more importantly, when the agency notified the Appellant of the increase in her monthly premium. The Appellant testified that she received notice in October or possibly November of the increase cost for her premium and also that the amount fluctuated. HSRI did indicate that the increase occurred in April 2014 when the Appellant may have changed her income, although she doesn't recall doing so but HSRI did not indicate when they notified the Appellant of this change. If HSRI did inform the Appellant of the charge in the Appellant's premium, was it as of October/November when the Appellant received a notice from HSRI?

In accordance with Rhode Island Policy Manual, Chapter 12 – Termination, Billing Late Payments § J

Individuals and employers will be considered overdue when they have not paid their monthly bill in full by the designated due date. Individuals that have elected to receive an APTC who are overdue will receive a late notice; the notice will include the amount overdue, any applicable grace period, and the expected coverage termination date. APTC recipients are eligible for a 3-month grace period, but only if they have previously paid at least one full month's premium. Employers and individuals that did not elect an APTC who are overdue have a one-month grace period and will receive intent to terminate notice at least 30 days prior to termination effective date.

Late payment notices will be generated on the 26th of every month.

For APTC recipients, invoices, late & termination notices will be sent during the delinquency process as follows:

- On the 26th day of the first month of late-payment a notice indicating the non-payment of premium and the time remaining in the grace period will be included as a message text within the monthly invoice.
- On the 26th day of the second month of non-payment a notice indicating the non-payment (separate from the invoice) as well as a text regarding the grace period will be included within the monthly invoice.
- On the 26th day of the third month of non-payment a notice indicating the non-payment and the intent to terminate will be sent as a stand-alone letter. The monthly invoice will be sent independent of this notice...
- On the 1st day of the fourth month of non-payment a notice will be sent advising the enrollee that their coverage has been terminated.

The only termination notice that was presented at Hearing was the April 12, 2014 "Medicaid Termination Notice". Yet the Appellant provided undisputed testimony that she was verbally informed in October/November that she had already lost her healthcare insurance; no testimony was presented by either side as to when coverage was lost. Furthermore, there was no evidence submitted that indicates that one late payment notice ever was issued or received, never mind three which policy mandates.

If the Appellant is behind in her monthly premium payment, the agency did correctly apply any payment received from the Appellant to her oldest debt. The Rules and Regulations Pertaining to the Rhode Island Health Benefits Exchange requires that payments to be applied in chronological order, beginning with the oldest outstanding premium payment.

12.2 Payments to the Trust. Qualified individuals and qualified employers may remit premium payments to the Exchange to maintain participation in a QHP in accordance with all requirements under the Act and the Federal Regulations.

- a) Premium payments may be made in advance of the coverage month to which the payment applies.
- b) The monthly premium payment deadline shall be established by the Exchange.

- c) Premium payments will be applied against open premium lines in chronological order, beginning with the oldest outstanding premium payment.
- d) Payments may be received by the Trust from qualified individuals and employers for such products and services as may be offered through the Exchange.

ACTION FOR THE AGENCY

HSRI is to determine when they informed the Appellant of her change in her monthly healthcare premium and inform the Appellant what she owes for each of those months after she was informed of the increase. The Appellant was informed that she lost her healthcare cover, therefore due to the Appellant not receiving a notice informing her that her coverage had ended, HSRI will issue the termination notice to the Appellant. HSRI will apply any payment in which the Appellant made to her past-due balance, if one exists.

Also, HSRI is to inform the Appellant and this Hearing Officer of all the above actions in writing and these actions are to be completed within 30-days of this decision.

After a careful review of the Agency's policies, as well as the evidence and testimony given, this Appeals Officer finds that this issue is remanded back to the agency, HSRI.

Please note that the final calculation of tax credits is conducted by the federal Internal Revenue Service through the reconciliation process, in accordance with § 36 B (f) of the Internal Revenue Code and that decision(s) or interpretation(s) of the EOHHS Appeals Office is not binding against the IRS during that process.



Appeals Officer

APPENDIX

**EXECUTICE OFFICE OF HEALTH AND HUMAN SERVICES (EOHHS)
MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)**

**RULES AND REGULATIONS PERTAINING TO THE RHODE ISLAND HEALTH
BENEFITS EXCHANGE**

- 12.2 Payments to the Trust. Qualified individuals and qualified employers may remit premium payments to the Exchange to maintain participation in a QHP in accordance with all requirements under the Act and the Federal Regulations.
- a) Premium payments may be made in advance of the coverage month to which the payment applies.
 - b) The monthly premium payment deadline shall be established by the Exchange.
 - c) Premium payments will be applied against open premium lines in chronological order, beginning with the oldest outstanding premium payment.
 - d) Payments may be received by the Trust from qualified individuals and employers for such products and services as may be offered through the Exchange.
- 12.3 Overdue Accounts. Individuals and Employers will be considered overdue when they have not paid a monthly bill in full by the designated due date.
- a) Overdue accounts will receive a late notice including the payment amount overdue, any applicable grace period as defined in §8.3 or §10.11 of these Regulations, and the expected coverage termination date.
 - b) Late notices will be mailed and delivered electronically into the individual's or employer's account.

SECTION 9.0 AGREEMENTS WITH ISSUERS

9.1 In General. The Exchange shall establish a certification process for all participating QHP Issuers.

9.2 Issuer Agreements. All QHP Issuers must enter an Issuer Agreement with the Exchange describing the issuer's obligations with regard to offering products and/or services on the Exchange.

- (a) Issuer Agreements shall be negotiated on an annual basis and formed in advance of the Annual Open Enrollment Period for the upcoming benefit year.
- (b) QHPs offered through the Exchange pursuant to an Issuer Agreement may vary from year to year.

Rhode Island Policy Manual

Chapter 12 – Termination, Billing and Late Payments

J. Late Payment

Individuals and employers will be considered overdue when they have not paid their monthly bill in full by the designated due date. Individuals that have elected to receive an APTC who are overdue will receive a late notice; the notice will include the amount overdue, any applicable grace period, and the expected coverage termination date. APTC recipients are eligible for a 3-month grace period, but only if they have previously paid at least one full month's premium. Employers and individuals that did not elect an APTC who are overdue have a one-month grace period and will receive intent to terminate notice at least 30 days prior to termination effective date.

Late payment notices will be generated on the 26th of every month.

Individuals who do not qualify for APTC and employers who continue to be delinquent 1-month beyond the overdue date will be terminated for non-payment. Individuals who qualify for an APTC and therefore have a 3-month grace period will be terminated for non-payment if payment is not received by the end of the grace period.

Late notices and notices of termination will be both mailed and delivered electronically regardless of the enrollee's preferred method.

Invoices, late & termination notices sent during the delinquency process will be sent to individuals who do not receive APTC's and employees/employers in the following order:

- Immediately following non-payment, a notice indicating the non-payment and the one-month grace period will be included as message text within the monthly invoice.
- The enrollee will also receive a separate intent to terminate notification indicating the expected last day of coverage.

For APTC recipients, invoices, late & termination notices will be sent during the delinquency process as follows:

- On the 26th day of the first month of late-payment a notice indicating the non-payment of premium and the time remaining in the grace period will be included as a message text within the monthly invoice.
- On the 26th day of the second month of non-payment a notice indicating the non-payment (separate from the invoice) as well as a text regarding the grace period will be included within the monthly invoice.
- On the 26th day of the third month of non-payment a notice indicating the non-payment and the intent to terminate will be sent as a stand-alone letter. The monthly invoice will be sent independent of this notice...
- On the 1st day of the fourth month of non-payment a notice will be sent advising the enrollee that their coverage has been terminated.

1307.06 Determination of Household Income

To be eligible for Medicaid using the MAGI standards, an applicant's current monthly household income must meet the standard applicable to the applicant's MACC group when converted to the federal poverty level as shown below:

<i>MACC Groups</i>	<i>FPL Eligibility Threshold</i>
Adults	133%
Children and Young Adults	261%
Families	133%
Pregnant Women	253%

When calculating whether an applicant is income-eligible for Medicaid under one of these coverage groups, the following factors must be considered: the members of the applicant's household that must be included; types of countable income; current income and reasonably predicted changes; and conversion of monthly income to the federal poverty level (FPL) standards.

01. Countable household income --There are several differences in the way certain types of income are treated when using the MAGI for Medicaid eligibility just as there are with the rules of household construction. The subsection below identifies all forms of countable income included when determining MAGI-based Medicaid eligibility, including those that are specific to Medicaid eligibility only.

1. Adjusted Gross Income (AGI). Adjusted gross income is gross income adjusted by "above-the-line" deductions. AGI includes wages and salaries and income from a broad array of other sources, such as unemployment benefits, alimony, taxable interest, and capital gains. "Above-the-line" deductions are the adjustments people can make to their gross income. These include alimony payments, interest on student loans, and other items that appear on page one of Form 1040. However, they do not include charitable contributions, mortgage interest and other "below-the-line" deductions.
2. Social Security benefits. All Social Security income benefits are considered countable income when using the MAGI to determine eligibility for affordable coverage. This includes Social Security benefits that considered both taxable and non-taxable income for federal tax purposes.
3. Interest Income. Income received from bank accounts, money market accounts, certificates of deposit, and deposited insurance dividends are considered countable taxable income. Additionally, interest on some bonds issued by and used to finance state and local government operations is also counted for the MAGI even though treated as tax- exempt for federal tax purposes.
4. Foreign earned income. Foreign earned income is countable for the MAGI. This includes all income received from sources within a foreign country or countries earned for services when either performed by: a U.S. citizen and a bona fide resident of a foreign country for an uninterrupted period of time that includes an entire tax year; or a U.S. citizen or resident who, during any period of 12 consecutive months, is present in a foreign country for at least 330 full days during that period.
5. Medicaid specific adjustments to income. Special Medicaid adjustments are as follows:
 - (1) Lump sum payments (i.e., gifts, prizes, income and property tax refunds) are counted only in the month received.
 - (2) Educational scholarships, awards or fellowships used for education purposes are excluded from consideration as income.

- (3) Certain types of income for American Indian/Alaska Native individuals are excluded.
- (4) Treatment of other sources of income for Medicaid eligibility are summarized in the table that follows:

<i>MAGI-Based Medicaid Eligibility Rules</i>	
<i>Income Source</i>	<i>Treatment of Income on and after January 1, 2014</i>
Self-employment income	Counted with deductions for most expenses, depreciation, and business losses
Salary deferrals (flexible spending, cafeteria and 401(k) plans)	Not counted
Child support received	Not counted
Alimony paid	Deducted from income
Veterans' benefits	Not counted
Workers' compensation	Not counted
Gifts and inheritances	Not counted
TANF and SSI	Not counted

02. Household members included in MAGI calculation -- In general, the MAGI income of all individuals in an applicant's household must be counted toward household income with the following two exceptions:

- 01 Exception for the income of children. Unless a child is "expected to be required" to file a tax return, a child's income is not counted toward household income. The child's income does not count as part of household income when evaluating both the child's eligibility and the eligibility of other household members. This treatment of children's income also applies to adult children -- not just those under age 19 -- if they are tax dependents.
- 02. Exception for the income of most other dependents. The income of dependents who are not children or spouses is included as countable in the household income of the person who is claiming them (i.e., the claiming tax filer) only if they "are expected to be required" to file a tax return. The exception for most other tax dependents does not apply to spouses who are claimed as a tax dependent.

These exceptions are based on whether or not a person is "expected" to be required to file a tax return; it does not matter whether they eventually do so or not.

03. Use of current income & accounting for reasonably predicted changes -- For new Medicaid applicants, the Medicaid agency must use a household's

current monthly income and household size when evaluating eligibility. A prorated portion of reasonably predictable changes in income, if there is a basis for anticipating the changes, such as a signed contract for employment, a clear history of predictable fluctuations in income, or other indications of future changes in income may be considered in determining eligibility. Future changes in income and household size must be verified in accordance with the verification and reasonable compatibility requirements are delineated in MCAR section 1308.

04. Comparing household income to the Federal Poverty Level (FPL) – To determine income eligibility for Medicaid based on the MAGI calculation, the Medicaid agency must compare a household's current monthly income to the FPL guidelines for the appropriate household size. The Medicaid agency must use the most recently published FPL level in effect in the month during which an applicant applies for coverage. If an applicant's FPL level is within five (5) percentage points over the FPL for the coverage group for which they would be eligible, a disregard of five (5) percentage points of the FPL shall be added to the highest income eligibility standard listed above for that coverage group.

1308.02 Scope and Purpose

Beginning on January 1, 2014, all new applicants in the Medicaid Affordable Care Coverage (MACC) groups identified in section 1301 of the Medicaid Code of Administrative Rules (MCAR) are required to complete the same single, streamlined application as all other persons seeking coverage through the new web portal that serves both Medicaid and HealthSourceRI. The application seeks basic information about everyone who is applying for affordable coverage, irrespective of payer – that is whether the coverage is paid for in whole or in part by Medicaid, tax credits, subsidies, or the applicant and/or an employer. The basic information applicants must provide for everyone applying for coverage includes, but is not limited to: names; household composition; Social Security Numbers (if they have one), residency; Modified Adjusted Gross Income (MAGI); citizenship and immigration status; date of birth; access to health insurance; and whether anyone is incarcerated.

The purpose of this rule is to identify the principal facets of the verification process, including the electronic matches made through the federal data hub and State automated data bases and alternatives. In addition, the provisions of this rule also set forth the respective roles and responsibilities of the Executive Office of Health and Human Services (EOHHS), in its capacity as the Single State Medicaid Agency (Medicaid agency), and applicants in assuring this process functions in the most secure, effective, and efficient manner possible.

1308.04 Synopsis of Verification Process

New individuals and families seeking attest to the truthfulness and accuracy of the information they provide when applying by signing the completed application form under penalty of perjury. The Medicaid agency requires varying degrees of verification or corroboration of the applicant attestations – sometimes referred to as self-attestations – depending on the eligibility factor (see Section 1308.05 for details). For example, self-attestations are accepted without verification for residency, household composition, pregnancy and caretaker relative status. For all other eligibility factors, the Medicaid agency requires electronic verification of applicant attestations through one or more federal and/or State data sources. In instances in which an applicant's attestations on an eligibility factor conflict with data from the electronic data source, the Medicaid agency uses several different approaches to reconcile the differences. Paper documentation may be required. There are also a limited number of instances in which post-eligibility verification may be necessary (e.g., immigration status). In general, this verification process proceeds as follows:

6. Data matching – The Medicaid agency must assure that an applicant's information is entered into the eligibility system and matched electronically to the full extent feasible through the federal data hub and State data sources.
 - (1) Federal Data Hub. The federal data hub contains electronic information from various agencies of the United States government, including the Internal Revenue Service (IRS), Social Security Administration (SSA), Department of Health and Human Services (DHHS) (Centers for Medicare and Medicaid (CMS) and other agencies), Department of Homeland Security (USDHS), Department of Veterans Affairs (VA), Department of Defense (DoD), Peace Corps, and Office of Personnel Management (OPM). Various categories of data from these sources are used to match on income, employment, health, entitlements, citizenship, and criminal history. A full list of the data included in the federal hub and the rules governing its use are located in 42 Code of Federal Regulations (CFR) 435.948/949.
 - (2) State data sources. The State draws from databases from an array of public agencies including the RI Department of Labor and Training (DLT), the Department of Health (DOH), Division of Vital Statistics, the

Department of Administration (DOA), Divisions of Revenue and Motor Vehicles, and EOHHS agencies including DHS.

3. Reasonable compatibility – The Medicaid agency must use a reasonable compatibility standard to match data sources with self-reported application information. Attestation and data sources are reasonably compatible if any differences or discrepancies that emerge during the verification process are insufficient to affect the eligibility of the applicant. If the data sources match the applicant's attestation, or are found "reasonably compatible," the Medicaid agency must ensure that the eligibility system bases the determination on the information in the application. The Medicaid agency uses this standard for income verification and may apply it to other eligibility factors in the future.
4. Reasonable explanation – The Medicaid agency must provide the applicant with the opportunity to provide an explanation, and if necessary documentation, if the data sources do not match the attestation, or are not reasonably compatible. Accordingly, the automated eligibility system issues a request to the applicant for this information and provides a list of reasonable explanation options.
5. Reconciliation process – The explanation provided by an applicant must be used to determine whether it is feasible to reconcile a discrepancy between an attestation and data matches to determine whether reconciliation is feasible. If the applicant's provides an accepted reasonable explanation, the final determination of eligibility will be based on the information the applicant provided. If the applicant is unable to provide an accepted reasonable explanation, documentation is then required to verify or correct the attestation and reconcile the discrepancy.
6. Privacy – The verification process utilizes personally identifiable information (PII) from both the federal data hub and State data sources. An account is maintained for each person who completes and submits an application through the State's eligibility system. This account includes PII and other eligibility-related related information used in the determination and annual renewal process. The Medicaid agency must assure the privacy of the information in these accounts in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information and Rhode Island General Laws 40-6-12 and 40-6-12.1. Also, the Medicaid agency must limit any use of

account information to matters related to the administration of the Medicaid program including eligibility determinations, Medicaid health plan enrollment, appeals, and customer services.

7. Account Duration --Once an account in the eligibility system is established, a person seeking Medicaid has ninety (90) days to complete and submit the application for a determination. The eligibility system eliminates the account and all eligibility information from all sources, federal and State, if an application has not been completed by the end of that period. The Medicaid agency must determine eligibility within thirty (30) days from the date the completed application is submitted.

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.

This hearing decision constitutes a final order pursuant to RI General Laws §42-35-12. An appellant may seek judicial review to the extent it is available by law. 45 CFR 155.520 grants appellants who disagree with the decision of a State Exchange appeals entity, the ability to appeal to the U.S. Department of Health And Human Services (HHS) appeals entity within thirty (30) days of the mailing date of this decision. The act of filing an appeal with HHS does not prevent or delay the enforcement of this final order.

You can file an appeal with HHS at <https://www.healthcare.gov/downloads/marketplace-appeal-request-form-a.pdf> or by calling 1-800-318-2596.