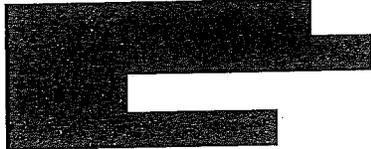




Rhode Island Executive Office of Health and Human Services  
Appeals Office, 57 Howard Ave., LP Building, 2<sup>nd</sup> floor, Cranston, RI 02920  
phone: 401.462.2132 fax: 401.462.0458

May 29, 2015

Docket # 15-378  
Hearing Date: April 1, 2015



## **ADMINISTRATIVE HEARING DECISION**

The Administrative Hearing that you requested has been decided partially in your favor. During the course of the proceeding, the following issue(s) and rules(s) and regulation(s) were the matters before the hearing:

**EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES (EOHHS)  
R.I. MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)  
SECTION 0332: Budget Periods  
SECTION 0368: Flexible Test of Income**

The facts of your case, the pertinent Agency rules and regulations, 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 Richard Pray, Edward Morgan, Vincent Guglielmino, and Nancy DelPrete.

Present at the hearing were: You, and Agency representatives Richard Pray and Edward Morgan.

**ISSUE:** Is the appellant's Medicaid eligibility start date of December 17, 2014 correct?

### **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.

## DISCUSSION OF EVIDENCE:

### The Agency representatives testified:

- On February 2, 2015 the Agency received a bill from Newport County Mental Health for \$1,080.71. The date of service for that bill was December 17, 2014.
- On February 3, 2015 the appellant was sent a notice informing him that he had met his flex spend down. This made the appellant eligible from December 17, 2014 through April 30, 2015.
- The appellant is not Medicaid eligible until the December 17, 2014 because that is the date of service for the bill that met his flex amount.
- The appellant had been Medicaid eligible previously after meeting a prior flex amount, but that flex period and Medicaid eligibility ended on October 31, 2014.
- The appellant did not receive a closure notice telling him that his Medicaid ended on October 31, 2014. He was told that his Medicaid would end on October 31, 2014 in the approval letter he was sent when he met his flex.
- The appellant had received a notice dated May 14, 2014 which informed him that he was ineligible for Medicaid due to excess income and that his six month flex period would be from May 1, 2014 thru October 31, 2014.
- A bill was submitted in July 2014 showing a date of service of May 18, 2014 and on July 29, 2014 the appellant was sent a notice telling him that he met his flex spend down on May 18, 2014 and that he had Medicaid eligibility from May 18, 2014 through October 31, 2014.
- The appellant sent in another Medicaid application on October 9, 2014 to request Medicaid for November 1, 2014.
- On January 14, 2015 the appellant was sent a notice informing him that he was denied Medicaid because of excess income and that he had a flex amount of \$990.00 for the time period from November 1, 2014 through April 30, 2015.
- At the time of the December 21, 2014 notice which told him that his medical assistance remained the same, he only had MPP/QMBY eligibility, which is a Medicaid program which pays for his Medicare Part B premium.

- If the appellant had any medical bills for services rendered in November 2014, then he might have met his flex amount sooner than December 17, 2014.
- He did tell the appellant to send in the \$77.00 bill for review but it would only alter the Medicaid start date if it was enough to meet his flex sooner, but it was not.
- The \$77.00 East Bay bill was never used towards the appellant's flex spend down because the Newport county bill was used and that exceeded the spend down.

**The appellant testified:**

- He was receiving Medicaid and submitted another Medicaid application on October 9, 2014.
- On December 21, 2014 he received a notice from the Agency telling him that his Medical Assistance coverage remained the same, which he believed meant he still had Medicaid.
- He never received a letter prior to that telling him that his Medicaid was closing.
- He did receive the January 14, 2015 letter which told him he was ineligible for Medicaid and about the flex test of income, but did not fully understand it.
- Each time he goes to East Bay Community Action they ask to see his Medicare and Medicaid cards and they check on the computer to make sure he has medical coverage. Every time he went in November and December 2014 they told him he had complete coverage, meaning he had both Medicaid and Medicare eligibility.
- He has received a \$77.00 bill from East Bay CAP for November and December, which the Agency is refusing to pay.
- He was also told by his DHS worker to fax over the \$77.00 bill and that it would be covered. East Bay told him that they also spoke to the DHS worker and were told the \$77.00 bill would be paid.
- He also went to Newport County Mental Health in November so he does not know why the \$1,080.71 bill that was submitted does not show any bill for November.
- The State does and has been paying his Medicare Part B premium.

**FINDINGS OF FACT:**

- The appellant was sent a notice dated January 14, 2015 informing him that he was ineligible for Medicaid because his income exceeded the program's income limits. The notice also informed him that he had \$990.00 of excess income for the six month time period from November 1, 2014 through April 30, 2015 and explained the Flexible test of Income rule/procedure by which he might obtain some Medicaid eligibility.
- On February 2, 2015, the Agency received a copy of a bill totaling \$1,080.71 for services rendered by Newport County CMHC on six separate dates.
- On February 3, 2015, the appellant was sent a notice informing him that he had met the flex spend down for the Medical Assistance Program on December 17, 2014. The February 3, 2015 notice also informed the appellant that he would be eligible for Medical Assistance from December 17, 2014 through April 30, 2015.
- The appellant filed a timely request for hearing received by the Agency on February 9, 2015.
- An Administrative Appeal Hearing was convened on April 1, 2015.
- The appellant has countable monthly income of \$1,032.00.
- The Medically Needy monthly income limit for an individual is \$867.00.
- At Hearing, the appellant submitted a bill totaling \$77.00 for services rendered by East Bay Community Action Program on three separate dates.
- Per the appellant's request, the record of hearing was held open for two weeks, through the close of business on April 15, 2015, to allow him to submit additional evidence. For the appellant's convenience, all additional evidence was to be submitted to the local DHS office and then immediately forwarded to the Appeals Officer.
- Upon receiving no additional evidence or contact from the Agency, the Appeals Officer contacted the Agency by email on April 21, 2015 to inquire whether any additional evidence was received from the appellant.
- The Agency notified the Appeals Officer per email on April 23, 2015 that no additional evidence had been received from the appellant.

- Two unsuccessful attempts were made to contact the appellant by telephone to confirm that he had not submitted any additional evidence during the held open period.
- The Appeals Officer sent a letter to the appellant dated April 28, 2015 informing him that no additional evidence had been received during the held open period.
- As of the date of this decision, the appellant has made no contact with the Appeals Office to dispute that he submitted no additional evidence during the held open period.

### **CONCLUSION:**

The issue to be decided is whether the appellant's Medicaid eligibility start date of December 17, 2014 is correct.

The record establishes that the appellant submitted an application for Medicaid on October 9, 2014 to request Medicaid eligibility beginning November 1, 2014. On January 14, 2015, the appellant was sent a notice informing him that he was ineligible for Medicaid because his countable monthly income exceeded the Medically Needy monthly income standard of \$867.00. The notice also informed the appellant of the Medicaid Flexible Test of Income rules which would allow him to obtain some Medicaid eligibility by spending down his excess income. On February 3, 2015 the appellant was sent a notice informing him that he had met the flex spend down on December 17, 2014 and was thereby Medicaid eligible from December 17, 2014 through April 30, 2015.

Per the MCAR's Flexible Test of Income rules, when an applicant's income exceeds the medically needy income limit, eligibility for Medicaid may be established if the applicant spends down his excess income, which is projected over a six-month period. The date of eligibility is the date on which the applicant incurs a medical expense that reduces his income to the income standard. Medicaid income eligibility then remains for the balance of the six-month time period.

The appellant does not dispute the Agency's calculation of his income as it appears on the January 14, 2015 Medicaid denial notice. Per that notice, the appellant has countable monthly income of \$1,032.00 or \$6,192.00 when projected over the six month time period. As the Medically Needy Income Limit for an individual is \$867.00 monthly or \$5,202.00 for six months, the appellant has excess income of \$990.00 for the six-month time period from November 1, 2014 through April 30, 2015 and he is thereby ineligible for Medicaid until he presents bills of allowable medical expenses which total \$990.00. This is referred to as his flex amount.

The Agency testifies that an allowable medical expense totaling \$1,080.71 for services rendered by Newport County CMHC was received by the Agency on February 2, 2015 and was credited towards the appellant's flex amount, thereby resulting in his Medicaid eligibility. The Agency further testifies that the appellant's Medicaid eligibility begins on December 17, 2014 because that was the date he incurred the medical expense that exceeded his flex amount of \$990.00.

The appellant argues that he was Medicaid eligible in November 2014 and has a \$77.00 medical bill for services rendered at East Bay Community Action Program (CAP) that should be paid by Medicaid. He testifies that every time he went to East Bay CAP in November and December, they checked his insurance in the system and told him he was fully covered by both Medicare and Medicaid. He further testifies that he received a notice from the Agency dated December 21, 2014 which told him that his Medicaid eligibility stayed the same. The appellant also claims that he should have additional November medical bills from Newport County CMHC, which could be submitted to the Agency for consideration. The appellant submits verification of the \$77.00 East Bay CAP bill at hearing. Per his request, the record of hearing was held open to allow him to submit verification of additional bills from Newport County CMHC. No additional medical bills were submitted while the record of hearing was held open.

A full review of the record of hearing finds evidence and testimony establishing that the appellant was previously notified that he had been granted Medicaid eligibility from May 18, 2014 through October 31, 2014, and that under the flexible test of income rules his Medicaid eligibility would automatically end on October 31, 2014 without any additional notification. All subsequent Medical Assistance notices issued prior to the January 14, 2015 denial notice thereby pertained to the appellant's eligibility for the Medicare Premium Payment Program, which continued uninterrupted. While the appellant testifies that staff at East Bay CAP told him in November and December 2014 that he was Medicaid eligible, the evidence record establishes that his Medicaid eligibility ended on October 31, 2014 and was not reinstated until December 17, 2014. Regardless of any misinformation East Bay CAP may have provided to the appellant, only the Department of Human Services (DHS) can determine and authorize Medicaid eligibility.

Further review of the MCAR finds that excess income is applied to documented medical expenses as they are incurred until all the excess income is reduced to zero. Once all of the excess income is absorbed by allowable medical expenses, Medicaid eligibility begins as of the date of the medical service which reduced the excess income to zero and Medicaid eligibility continues for the time period that remains in the six month flex period. The record establishes that the appellant has excess income of \$990.00 for the flex period from November 1, 2014 through April 30, 2015. The Agency concedes that the appellant has an allowable medical expense totaling \$1,080.71 from Newport County

CMHC. The Agency also concedes that the medical expense totaling \$77.00 incurred at East Bay CAP and presented at hearing is also an allowable medical expense. The Agency further testifies that the East Bay CAP bill would have been applied to the appellant's excess income first, if it had been submitted to the Agency.

A review of the East Bay CAP bill finds that \$29.20 was incurred on November 13, 2014; \$18.60 was incurred on December 2, 2014; and \$29.20 was incurred on December 4, 2014. Further review of the Newport County CMHC bill finds that the \$1,080.71 is a total amount owed for services rendered on six separate dates, as opposed to being fully incurred on December 17, 2014 as testified to by the Agency. Some of the Newport County CMHC services were rendered before the East Bay dates of service and some after. Further review of both medical bills, specifically as to the amounts and dates of service, finds that if the appellant's excess income had been applied towards his documented allowable medical expenses in the order in which they were incurred and/or the dates of service, his excess income would have been reduced to within the medical needy income standard on December 3, 2014. In summary, the appellant met his flex spend down on December 3, 2014 as opposed to December 17, 2014.

In conclusion, the record establishes that the appellant's prior Medicaid eligibility ended on October 31, 2014. While the appellant reapplied for November 2014 eligibility and alleges that he was eligible for Medicaid in November 2014, the record establishes that his countable income exceeded the Medically Needy Income limit as of November 1, 2014, thereby rendering him ineligible for Medicaid until his excess income was reduced to within the standard under the Medicaid flexible test of income rules. The record establishes that the appellant reduced his income to within the standard on December 3, 2014, thereby rendering him eligible for Medicaid from December 3, 2014 through April 30, 2015.

After a careful review of the MCAR, as well as the testimony and evidence submitted, this Appeals Officer finds that the appellant's Medicaid eligibility start date of December 17, 2014 is incorrect. The appellant's request for relief is partially granted

### **ACTION FOR THE AGENCY**

The Agency is to authorize Medicaid income eligibility for the appellant for the time period from December 3, 2014 through April 30, 2015. The appellant can request that any medical bills incurred after December 3, 2014 be resubmitted to Medicaid to determine if they qualify for payment.

Pursuant to EOHHS Regulation 0110.60.05, action required by this decision, completed by the Agency representative, must be confirmed in writing to this Appeals Officer.

A handwritten signature in black ink, appearing to read "Debra L. DeStefano". The signature is fluid and cursive, with the first name "Debra" and last name "DeStefano" clearly distinguishable.

Debra L. DeStefano  
Appeals Officer

**APPENDIX**

## MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)

(Pertinent excerpts)

### 0332 BUDGET PERIODS

#### 0332.05 DEFINITION OF A BUDGET PERIOD

REV:07/1994

A BUDGET PERIOD is the period of time against which the applicant's income is measured for the purpose of determining income eligibility. Categorically Needy cases have a one-month budget period. Medically Needy cases have a six-month budget period. When a change in circumstances occurs within a 6-month budget period, the current budget period is shortened and a new budget period begun.

#### 0332.10 MEDICALLY NEEDED BUDGET PERIODS

REV:01/2002

An applicant who meets all other eligibility requirements, but has income in excess of the Medically Needy income limits for the size of his/her family may be eligible for MA in accordance with the Flexible Test of Income (See Section 0336 - Flexible Test of Income).

Flex Test cases are determined for a six (6) month period beginning with the first day of the month in which the application is received. Eligibility as Medically Needy is not established, however, until the applicant has presented 1) receipts for medical services incurred during the period of determination and/or 2) unpaid bills incurred either during the current period of determination and/or prior to application for which the individual is still liable equal to the amount of such excess income. If the applicant is determined eligible via spenddown, the applicant is certified for six months or for the balance of the six (6) month budget period remaining when the excess income is absorbed.

FLEX CASES - Cases achieving Medically Needy eligibility because of having met a spenddown are initially approved for the balance of the original six-month budget period. Such case will automatically close on the last day of this six-month certification period. The new flex test six-month budget period will begin the next day.

For example, a case's original flex test 6-month budget period is January 1 through June 30th. The case meets spenddown on March 22nd. The case is approved eligible beginning March 22nd and the certification period is for the balance of the six month period

(March 22nd to June 30th). The case auto closes June 30th. The case begins new flex test 6-month budget period July 1st.

FIP CASE WITH CURRENT MONTH CLOSING - When a FIP case is closed due to excess income only, the FIP portion of the case is discontinued and eligibility for continued Medical Assistance is redetermined. If the income is in excess of Medically Assistance Income Limits, the MA case is closed. The first month of the new flex test six month budget period begins the month of the MA closure.

### 0362.05 Income Standards – Individual/Couple

#### 2015 TABLE OF MEDICALLY NEEDEY MONTHLY INCOME LIMITS

1 Person	\$ 867.00	5 Persons	\$ 1,442.00
2 Persons	\$ 908.00	6 Persons	\$ 1,625.00
3 Persons	\$ 1,125.00	7 Persons	\$ 1,783.00
4 Persons	\$ 1,283.00	8 Persons	\$ 1,967.00

### 0368 FLEXIBLE TEST OF INCOME

#### 0368.05 USE OF EXCESS INCOME

REV:06/1994

An individual who meets the other eligibility requirements, but has income in excess of the Medically Needy income limits may be eligible for Medical Assistance in accordance with the Flexible Test of Income.

Flexible Test cases are determined for a six (6) month period beginning with the first day of the month in which application is received. Eligibility as Medically Needy is not established, however, until the applicant has presented 1) RECEIPTS FOR MEDICAL SERVICES INCURRED DURING THE PERIOD OF DETERMINATION and/or 2) UNPAID BILLS incurred either during the CURRENT PERIOD of determination AND/OR PRIOR TO APPLICATION for which the individual is STILL LIABLE equal to the amount of such excess income. The only exception is in the case of medical expenses which are paid by or are the liability of other medical care programs that are funded 100% with State funds. For example, a applicant's medical expenses that have been paid (or are to be paid) by the RIPAE or Rite-Care

programs are considered to be the liability of the applicant, and if otherwise allowable, are deducted from the spenddown liability. Medical expenses that are subject to payment by any other third party payer are not considered the liability of the applicant and are not deducted from the excess income.

In some cases, current payments ON THE PRINCIPAL BALANCES of loans to pay off old medical bills (i.e., bills incurred prior to the current budget period) are incurred health care expenses if certain conditions are met.

If the applicant is determined eligible under a flexible test of income, the applicant is certified for SIX (6) MONTHS OR FOR THE BALANCE OF THE SIX (6) MONTH PERIOD remaining when the excess income is absorbed.

### **0368.05.05 When Eligibility Begins**

REV:06/1994

The date of eligibility is the actual day of the month on which the applicant incurs a medical expense which reduces income to the income standard. THEREFORE, THE DATE OF ELIGIBILITY IS THE DAY THAT THE MEDICAL SERVICE IS PROVIDED AND NOT THE DATE OF THE BILLING, which may be a later date. The expense is incurred on the day of the service.

When an incurred medical expense is a hospital bill, the date of eligibility is the first day of hospitalization. An AP-758 is required to establish the amount of the hospital bill for which the individual is liable. The individual's liability is his/her excess income on the first day of hospitalization, providing there is no expense subsequently incurred which reduces such excess income to a lesser amount.

If the applicant has excess income and there is no indication of medical expenses by which the excess can be absorbed, the case is rejected. However, if the applicant should present medical expenses within the same six (6) month period, the original application is used in determining whether the excess income for this same six-month period has been reduced to the income standard.

## 0368.20 DEDUCTING RECOGNIZED MED EXP

REV:06/1994

In establishing financial eligibility, excess income is applied toward reasonable incurred medical expenses that are not subject to payment by a third party (other than those medical expenses which are the liability of or paid by 100% State funded medical care programs).

Determine the available excess income for the six (6) month period beginning with the month of application. Excess income can then be applied to recognized medical expenses incurred PRIOR to application and unpaid. If a medical expense is more than one (1) year old, it is necessary to ensure that the applicant is still liable for the payment. This can be done by presentation of a current billing. Apply the excess income to the medical expenses in the appropriate order.

Recognized medical expenses include medical insurance premiums, co-payments, deductibles and certain medical and remedial care expenses recognized under state law. Incurred medical expenses may also include current payments on the principal of loans used to pay off old medical bills.

Excess income is applied to the medical expenses in the following order:

FIRST: Deduct incurred medical insurance premiums, including any enrollment fee, Medicare premiums, capitation fees for enrollment in prepaid health care programs, and premiums for any other health insurance program which is primarily established for payment of medical costs. With the exception of Medicare premiums, the cost of such medical insurance must be actually incurred and MAY NOT BE PROJECTED over the six (6) months of the application period; Deduct any co-payments, co-insurance or deductibles under any health insurance program as they are incurred.

SECOND: Deduct necessary medical or remedial care recognized under state law but not provided within the Medical Assistance scope of services, such as chiropractic services, adult day care, respite care, or Home Health Aide/Homemaker services.

THIRD: Deduct necessary medical or remedial care provided within the Medical Assistance scope of services.

FOURTH: Deduct current payments on the principal balances of loans used to pay off medical bills incurred prior to the current budget period.

## 0368.30 CERTIFICAT OF FLEX TEST CASES

REV:06/1994

Each individual determined to be ineligible for MA will receive notice of the basis of ineligibility. Those individuals ineligible on the basis of excess income will be informed of the amount of his/her spenddown liability.

When a recipient's case is discontinued on the basis of income exceeding the Medically Needy income standard, a review of the recipient's situation is completed under the Flex Test policy. Such recipient is advised of the amount of excess income and the eligibility period during which such excess must be absorbed. When such applicant/recipient presents unpaid bills (for which the individual remains liable) incurred at any time through the final day of the six (6) month period and/or receipts for bills incurred during the period for which eligibility is being determined which total or exceed the amount of the excess income, eligibility exists for the balance of the six (6) month period. A new application is not needed for that six (6) month period. Any case certified, whether for a full six (6) month period or a balance of even only one (1) month, needs a new application at the end of each six (6) month period. The InRHODES system will trigger the mailing of a redetermination packet by sending a notice to the field office. Each six (6) month period is determined separately. Medical bills recognized in a previous Flexible Test period to reduce excess income must not be applied to reduce the excess income for the new application period. However, if the bills did not establish eligibility, then they were not used for spenddown and can be considered in a subsequent six (6) month period. To certify a case where the recipient and Medical Assistance must share the expense, the InRHODES eligibility system will notify MMIS of the bills that were used to meet the spenddown. These bills will not be paid by MMIS and are the applicant's responsibility.

### **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.