EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES
STATE OF RHODE ISLAND

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

July 22, 2015

Docket # 15-226
Hearing Date: June 23, 2015

[redacted]
C/o Aura L. Matos
RI REACH
1210 Pontiac Ave.
Cranston, RI 02920

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 regulation(s) were the matters before the hearing:

RULES AND REGULATIONS PERTAINING TO THE RHODE ISLAND HEALTH BENEFITS EXCHANGE (RIHBE)
SECTION 1.0 Definitions
SECTION 5.3 Individuals for Whom a Premium Assistance Amount Can Be Provided

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES (EOHHS) MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)
SECTION 1307 "MAGI" Income Eligibility Determinations
SECTION 1307.01 Scope and Purpose
SECTION 0110: Complaints & Hearings

Social Security Act, 42 USC § 1395ss (d)
Title 45, Public Welfare, CFR § 155.205

The facts of your case, the Agency 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: Your representative Aura L. Matos, and Health Source RI (HSRI) Agency representatives: Noah Zimmerman, and Lindsay Lang.

Present at the hearing were: You (the Appellant), your wife, the Spanish Interpreter, REACH representatives: Authorized representative-Aura L. Matos, Attorney Sam Salganik; and Agency representative Noah Zimmerman.

ISSUE: Can the appellant retroactively recoup premiums and tax credits as a result of an incorrect eligibility decision by HSRI beginning in January 2014?

RIHBE AND MCAR RULES AND REGULATIONS:
Please see the attached APPENDIX for pertinent excerpts from: the Rules and Regulations Pertaining to the Rhode Island Health Benefits Exchange, and from the Medicaid Code of Administrative Rules

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

DISCUSSION OF THE EVIDENCE:

The appellant's attorney and the appellant and his wife presented:

- There are three issues, (as presented in a letter brief) and the first issue relates to the 2014 coverage, in which the appellants were enrolled in a Qualified Health Plan (QHP) with tax credits, but she (appellant's wife) had Medicare for the whole year and was thus ineligible for tax credits.

- She gave her Medicare card to HSRI when she enrolled so HSRI knew she had Medicare and should not have awarded her tax credits.

- We are requesting that certain retroactive adjustments be made to resolve this error.

- The second issue relates to billing for 2015 coverage and we have asked for some adjustments. (The Agency agreed on record to rectify this to the appellant's satisfaction).

- The third issues arose because of coverage problems (2015), and the resulting coverage plan for the appellant may not be the plan of his choice, so we are requesting a special enrollment period for him to choose a new plan. (The Agency agreed on record to rectify this to the satisfaction of the appellant).

- The appellants agree that they are happy with the reconciliation of the first two issues.

WITH REGARDS TO TIMELINESS AS IT RELATES TO THE FIRST ISSUE:

- Regarding timeliness issues: we agree there are some, but due to a few reasons, an exception might be warranted. First, and most glaring is that we were informed by HSRI several times that retroactive adjustments would be made. The couple have taken some steps in relying on those

assurance such as requesting an extension on taxes.

- Second, this was a particularly egregious mistake as any professionals in this industry should have known from the day this ACA was signed into law that a Medicare recipient cannot also receive tax credits. In this case, the consequences fall entirely on the consumer. This is not a case where they got more tax credits than they should have for coverage that they needed, and then had to pay back the credits. This is a case where they received tax credits and coverage that they entirely didn't need and never used.

- Third, they filed appeal almost immediately after learning they had an issue because it would have been difficult for them to understand the problem until someone found it for them or until their 2014 taxes were completed. This is a rare case where the hearing officer does have the authority to rectify the tax credit issue, and make the consumer whole without harm to any medical providers with claims protracted. Blue Cross will have to pay back the premiums, but we do not consider this a hardship as Blue Cross sold a product to an ineligible consumer.

- The couple was not aware of the problem during 2014 because they most likely could not have understood this very complex problem, although this has very little legal bearing.

- They became aware of the problem when they tried to renew coverage in 2015; and, due to the escalation of numerous renewal problems at the time, Health Source became aware of the mistake that had been made in 2014.

- That's also the time that the Rhode Island Parent Information Network (RIPIN) became aware of this case after the appeal had been filed.

- We (RIPIN) had numerous conversations with HSRI where we were told that they (HSRI) would go back and make the retroactive adjustments. These conversations included a 2.19 Priority team call, a 3.2.15 Priority team call, and a string of emails (included in evidence) in which the Priority team and the RIPIN representatives were working through numbers to guide the retroactive adjustments.

- We (appellant and representatives) kept the hearing open only as a backup, because until recently it was understood that the adjustments would be made, as evidenced by a March 12, 2015 memorandum from us to HSRI in which we summarized the numbers, and recommended the adjustments.

- The family discovered from HSRI just recently on June 10th that the Agency would not be making the adjustments, and they should proceed with the hearing.

- We believe that HSRI is willing to stipulate to the mistake, and timeliness is now the only issue.

- The couple went into HSRI directly in November 2013.

- They did everything in Spanish at HSRI, and he (the appellant) was there (at HSRI) a lot of times from November (13') to January (15'), for two or three hours each time.

- There was a person who could speak Spanish at HSRI, and he remembers that he told them that if it (the paperwork) was in Spanish it would be better.

- We are aware that bills can come in Spanish and some of the words on some of the Invoices are in Spanish, but mostly in English.

- All the documents were sent to his home, and he did receive one document in Spanish sent to his home after he went to HSRI and spoke with them.

- The translator identified that the document "Rights and Responsibilities for Health Coverage", submitted by the appellant, and which identified the opportunity to request an appeal within 30 days after receipt of the notice of an action of the desired appeal.

- The document has no date, and it is unclear when it came, and from whom, and whether or not it was enclosed with any eligibility decisions, and we do not stipulate to the adequacy of the document.

- He (the appellant) did not remember exactly when he received the Spanish notice of his rights except that they sent him all the different papers, and it was received after he had paid for his insurance, and after they had

sent him all the papers in 2014.

- In late 2013 when first applying for health care coverage, the spouse (appellant's wife) provided a Medicare card, and she had Medicare coverage for all of 2014.

- Health Source knew, per the HSRI 2013 date stamp indicated on the copy of the Medicare card, that she had Medicare coverage and none-the-less, they awarded her tax credits that can result in the family having to pay back to the IRS credits they received.

- The attorney estimates they will owe $2500 due to the mistake, but is not sure of this figure, as he is not a tax attorney.

- They have filed a tax extension at this time, due to the issues.

- She (wife) never once used her coverage provided to her by Health Source because she knew she had the Medicare coverage.

- There are many similar 2014 cases like this where mistakes were made resulting in tax liability where there was nothing that the hearing officer could do to correct this.

- We understand the state does not have a fund to assist with paying what is owed for tax credits, and we understand that the hearing officer does not have the authority to order the state to do so, but this case is different.

- A retroactive correction to the initial incorrect eligibility decision would remove her from all coverage retroactively and would resolve the tax credit issue completely, and it would result in refund of premiums paid for coverage that they never used.

- Thus no claims would be reprocessed.

- Both appellant's received coverage cards, each in their own name, and at the time (2013/2014) he informed them (not clear who) that he already had a card.

- It appears that the appellant's wife is covered by United Health Insurance for Medicare purposes.

- Regarding the use of the Blue Cross coverage (through HSRI), if it was found that they used the coverage it could cause problems.

- The couple went directly to HSRI again in November 2014 and had an appointment around December 3rd to renew their coverage, and made their first payment by December 4, 2014 (for December), and were told he had to pay a credit owed the past year.

- They were given another appointment because the computer would not work, and then were told they would have to pay more, and then they asked about another insurance, and then he (the appellant) wrote another check for the same bill for January 1, 2015 but were then told, they owed money for another year. Due to the confusion, they (HSRI) began to help them.

- There were three notices received during their enrollment for 2015-a November 25th Eligibility notice, and a December 21, and a December 28th (2014) notice-which when read in conjunction with one another are incomprehensible, as they each give a different number for tax credit eligibility and the notices contradict each other about payment or lack of payment, and they contradict one another regarding enrollment or lack of enrollment, they contradict one another about whether it is an open enrollment period or not, and again a notice about special enrollment eligibility. No effective coverage dates are ever noted.

The Health Source Rhode Island (HSRI) representative testified:

- With regards to the second issue-the 2015 billing issue-the Agency will concede/or withdraw by allowing the retroactive adjustments for 2015 requested by the appellant.

- With regards to the third issue, we are willing to grant a special enrollment for the reason of Exchange error, or other exceptional circumstances. We have agreed that he will have 60 days from July 1, 2015 to enroll in a new plan.

- We are willing to admit our mistake in finding her (appellant's wife) eligible for a QHP (qualified health plan) and tax credits in November, as she submitted proof of her Medicare eligibility in 2013.

- We either disregarded that information, or the worker did not understand, and as a result she was found eligible for a QHP and was signed up for a plan and was given tax credits we should not have given her.

- Had that individual been properly trained or understood they would have made the correct decision and denied her coverage on the Exchange.

- We admit that there were conversations with the Priority team and customer service representatives which allowed the appellant to have a reasonable expectation that this retroactive termination and recouping of other premiums would be rectified, but the final step to submit a work order never took place, as determined by senior leadership. It was determined that although earlier promises were made, those who made them were not in a position to do so as they should have been made at a higher level.

- Notices were sent to the home, and no rights are in English, although we provide a line at the bottom of the front page which is in Spanish and says if you have

any questions, or need an interpreter, you can call HSRI at the number presented.

- The notice does not break down the separate premium amounts for each individual, but lists the total premium, so we can understand how it would have been difficult for the appellant to understand the bill applied to both he and his wife, not just for him.

- An Invoice in English dated November 13, 2013 shows the first payment for their plan for 2014, and it lists a tax credit for $845.31.

- There is an Enrollment notice dated December 12, 2013 which shows the couple enrolled in Blue Cross/Blue Shield and would pay a monthly bill of $503.39, but which does not identify the tax credits.

- When they applied in 2013, according to the Dashboard readout, we agree that they did show/request a preference for the language spoken/or read as Spanish as can be seen under their household account information submitted.

- Regarding HSRI's response to a client choosing a language preference on their application-the HSRI representative stated, it is our "understanding that when it comes to notices and Invoices, we (HSRI) do not have the capacity to send those" in other languages.

- Each notice sent to the appellant also comes with rights attached, and they are in English.

- We are not familiar with the Rights and Responsibility document presented by the appellant in Spanish.

- The Agency agrees to submit the December/January 2014 notices post hearing, and will determine post hearing if the notices are sent in a language other than English if a preference for another language is requested; and, the Agency will determine if there was any use of the Blue Cross coverage for the appellant.

- We believe that nonuse of the insurance by the appellant's wife has been confirmed.

FINDINGS OF FACT:

- On January 14, 2015 the appellant filed a timely appeal on a December 21, 2014 notice of Eligibility.

- A hearing was held on June 23, 2015.

- Two of the three issues under dispute were reconciled at hearing.

- A timeliness finding was required on the third issue.

- The record of hearing was held open until June 30th for submission of additional evidence from the Agency, and continued held open until July 7, 2015 for the appellant to respond to that evidence submitted.

- Additional evidence was submitted prior to the close of hearing, and the appellant responded within the time frames.

- The appellant's contact information submitted by the Agency showed that the appellant requested verbal and written documentation in Spanish. He received all correspondences including his rights to appeal, in English.

- Per Federal Regulations and a 2011 US Department of OHHS for Civil Rights and DHS Resolution Agreement, the appellant had a legal right for receipt of notices in Spanish.

- A copy of the appellant's wife's' Medicare card submitted to HSRI and date stamped, November 12, 2013 read, "MedicareComplete", and indicated United Healthcare coverage.

- A December 9, 2013 Eligibility Decision Notice informed the appellant of coverage for him and his wife, included the tax credit allowance, and indicated an effective date of January 1, 2014.

- Federal regulations and HSRI regulations do not allow sale of duplicate coverage to Medicare applicants.

- Federal regulations do not allow receipt of tax credits for Medicare recipients.

- The appellant's "dashboard" computer read out submitted by the Agency showed that the appellant, when asked, "Applying for Coverage?" answered "Yes" for himself/and "No" for his wife.

CONCLUSION:

The first issue to be decided is whether the appellant's appeal is timely. An Agency notice dated December 21, 2014 was introduced at hearing and the appellant filed a timely appeal on January 14· 2015. A claimant has an "opportunity to present his/her case to the appropriate state agency authority for resolution" -in this case-within 30 days from the date of the notice. Two of the three issues were undisputedly timely, and both were resolved at hearing, and will not be addressed further in this decision, except to identify the resolution. The appellant's attorney argues that the third issue, which began January 2014 should be considered timely for several reasons, some of which were

presented post hearing. He argues that the Agency in early 2015, agreed, and actively participated in, negotiations to retroactively make adjustments for the appellant. They later reneged. Second, the "potential Social Security Act violation" of HSRI should compel the Agency to rectify the issue. Third, the lack of receipt of notices in the appellant's own language prevented the appellant from adequate notice of his rights to appeal. Lastly, the family would most likely have been unaware that they had been wronged until it was pointed out to them or they had completed their taxes. It was eventually HSRI themselves who pointed the mistake out to them.

The appellant went to HSRI directly in November 2013, and applied for health care coverage. All discussions between him and the Agency were conducted with Spanish speaking representatives. Evidence demonstrates that at the time, the appellant filled out his application and checked the box which indicated his preference for language spoken and language read, as-Spanish. He further testified that he informed the representative that if the paperwork were in Spanish it would be better. The record establishes that all subsequent notices, and their attached appeal rights were in English only, as were all Invoices with the exception of the word tax credit which later appeared in Spanish on notices in late 2014/early 2015. The appellant's attorney, post hearing, cited Federal Regulations and presented a copy of the 2011 US Department of Justice Resolution Agreement between the US Department of Health and Human Services Office for Civil Rights and RI DHS. He opines that Federal regulations require that the Exchange provide notices to individuals with limited English proficiency; and, that the Resolution Agreement requires written translations of vital documents in any language spoken by at least 5% of the population likely to be served by DHS programs or 1,000 persons in the population, whichever is less. He further cites a recent (2013) Census Bureau estimate of 105,000 RI residents who speak Spanish at home. The appellant also presented that sometime after signing up for coverage, and paying for coverage, and after his coverage had begun he received a correspondence with "all the different papers". He presented a written copy of a Spanish translation of "Rights and Responsibilities for Health Coverage", which indicated that he could request an appeal within 30 days after receipt of the notice of an action. The appellant's attorney argues that it was not clear that this document was enclosed with any eligibility decisions. He presents that it is not dated, and it is unclear when and from whom it came.
The Agency agreed that the appellant had requested a Spanish preference for both orally and written materials in his initial application. They testified that they did not believe that the Agency had the capacity to offer the notices and Invoices in languages other than English. The Agency did not establish post hearing, whether or not HSRI had the "capacity" to produce notices in Spanish. With regards to the Spanish translation of the document with the heading "Health Care Rights and Responsibilities", received by the appellant, the Agency presented post hearing that the document is the third page of the Health Care Application, but testified he was unsure when and how it was received by the appellant.

With regards to the Rights and Responsibilities document translated into Spanish, the appellant provided credible testimony that he was unsure when the document was received. The appellant conducted all his business at the HSRI facility, and the Agency

failed to provide any evidence that the appellant was presented with the document at HSRI, or whether the document would have been provided with any subsequent notices. The appellant's right to appeal are part of the notices, and they were undisputedly all in English. The Agency did not establish whether or not HSRI had the "capacity" to produce notices in Spanish, but established that they did not do so. Further exploration of the Federal Regulations, and the Resolution Document presented by the appellant's attorney support his argument that the appellant had a legal right through the Americans with Disabilities Act and Section 504 of the Rehabilitation Act, to a notice written in Spanish. Undisputed evidence affirms the appellant's contention that he conducted all his business in person in Spanish, and that he was offered a language preference for written notices through the application. He furthermore requested Spanish notification, but received only English notices. As a result, the appellant did not have an opportunity to fully understand the possible mistake by HSRI, and was not given due process rights allowing him the choice of an appeal. For that reason, the remaining timeliness arguments will not be examined at this time, and the appellant's argument for timeliness based solely on due process issues, is granted.

The fundamental issue to be decided is whether the appellant can retroactively recoup premiums and tax credits as a result of an incorrect eligibility decision by HSRI in January 2014.

There is no dispute that HSRI assessed the appellant and his spouse for receipt of health insurance for a family of two, and assessed them as well for the corresponding tax credits. There is no dispute that the spouses' Medicare card, indicating her health coverage with United Health Insurance, was presented to HSRI, during application. There is no dispute that the appellant's spouse should not have been assessed for insurance for herself, or for the corresponding tax credits.

Advanced premium tax credits (APTC's) are payments of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health plan through the Rhode Island Health Benefits Exchange also known as Health Source Rhode Island (HSRI). The amount of premium credit the applicant should have received over the course of the benefit year is reconciled when the applicant files a tax return for that year. These premiums are affected by income, household size, and number of recipients in receipt of the health insurance. Further exploration of regulations pertaining to the Rhode Island Benefits Exchange identify that individuals are not eligible for premium tax assistance (APTC's) if they are already in receipt of minimal essential coverage.

The appellant went into HSRI when they first became operational in November 2013. At that time, an open enrollment period was established to implement the federal Affordable Care Act (ACA) eligibility system developed to make determinations for all forms of affordable coverage. One of the principal goals of the ACA was to improve access to affordable health care coverage paid for in part by federal tax credits and other subsidies. The appellant presented his wife's Medicare card which indicated current United Health Care coverage. The appellant's attorney argues that HSRI

violated section 1882(d) of the Social Security Act by knowingly selling duplicative health coverage. The attorney submitted additional evidence of publicized pronouncements of this type of violation both in the news, and in an August 2014 CMS (Centers for Medicare and Medicaid Services) publically issued document both of which he contends the HSRI representative should have been aware.

Post hearing, it was also determined that the appellant's wife had used the Blue Cross coverage, although this had not come to light at hearing. Investigation of this usage, showed that she used the coverage on 14 occasions. The appellant's attorney contends that in investigating these claims, it became apparent that Blue Cross/Blue Shield (BC/BS) had also violated the Social Security Act, as evidence revealed that BCBS to whom the appellant was paying the premium, rejected "many" claims based on their understanding that the spouse already had Medicare. He noted they were aware as early as January 2014.

The Agency agrees that the product was incorrectly sold to the appellant and his spouse, and maintains that the representative either "disregarded that information", or the worker "did not understand", and signed the spouse up for a qualified health plan (QHP) which she already had. He further opined that had the "individual been properly trained or understood they would have made the correct decision and denied her coverage on the Exchange."

Exploration of the Social Security Act supports the appellant's contention that it is illegal to knowingly sell or issue a health insurance policy to a Medicare beneficiary. The Agency stipulates to the error, but testifies that he is unclear if the HSRI worker intentionally sold the plan, or whether they were improperly trained and did not understand the issue. The Medicare card received and copied by the HSRI representative reveals that the appellant had Medicare **Complete** (added for emphasis) and that the carrier was United Health Care. Regardless of the representatives understanding of the Social Security Act, the representative was selling health insurance, and clearly took the time to copy the spouse's health insurance card which established that the applicant already received complete health insurance, thus establishing the representative was at least aware that she was selling the applicant a second policy. Thus, the representative also seemed "unaware" of their own policy, as HSRI regulations forbade the sale of the tax credits to this consumer as she already had minimal essential coverage. A "Dashboard" computer readout was entered into evidence at hearing, and the contact information section, which revealed the appellant's request for Spanish correspondence, was resubmitted post hearing by the Agency. Further exploration of the Account Home page reveals the date received as November 12, 2013; it reveals a request by the appellant for preferred language spoken and read-as Spanish; and, it reveals that the appellant's wife checked "No" when asked the question, "Applying for Coverage?" The appellant checked "Yes" for himself. In summary, the HSRI policy did not allow the sale of tax credits; the Federal policy did not allow the sale of duplicate insurance to a Medicare recipient; and, the appellant's wife, from the moment of application, said she did not want insurance. She was assessed for and received the insurance.

The appellant's representative noted post hearing, that 14 claims had been submitted to BCBS. He identified that it was unclear if the spouse had "inadvertently" presented the BCBS card to providers, or whether they may have submitted claims based upon information they had on file from past BCBS coverage. The attorney revealed that BCBS sometimes rejected the claims altogether, and on several, paid as secondary. He further determined that all but one of the 14 claims were "also" paid by United Health Insurance, and that Blue Cross was aware as early as January 2014 that the spouse had Medicare.

In summary, the appellant applied for health coverage in November 2013 during open enrollment. At the time, he presented his wife's Medicare coverage card which indicated she had complete insurance coverage through United Health care. His "dashboard" page indicates that he requested Spanish documents-but never received them, and he requested insurance for himself only, but received insurance coverage for him and his wife, as well as the corresponding tax credits. The 1882 (d) Social Security Act determines that is unlawful to sell an insurance policy to an individual who receives Medicare. Credible testimony and evidence suggests that both HSRI and BCBS were aware of the appellant's Medicare coverage resulting in a fraudulent sale of duplicate insurance. The RI Health Benefits Exchange (RIHBE) policy does not allow APTC's for those applicants who already have minimal essential coverage-which the appellant had through United Health Care. In short, the appellant received a product which should not have been sold to him per the Federal law, and per the Exchange regulations; which he did not want per the application request; which he did not need, per the Medicare coverage already in place; and which he may not have understood he had, per the lack of Spanish notices, which he requested. The appellant's request for relief is granted in that he can have all tax credits and premiums assigned to his wife removed retroactively from January 1, 2014 through November 30, 2014. The appellant will be responsible for rectifying any bills processed including resubmission of bills as needed, and repayment of Blue Cross copays if applicable. Blue Cross is no longer responsible for any bills/payments incurred on behalf of the appellant's wife between January and November 2014.

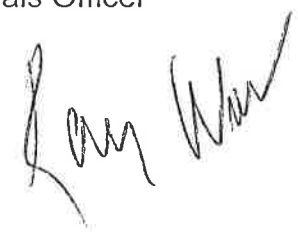
After a careful review of the Agency's regulations, as well as the evidence and testimony given, the Appeals Officer finds that the appellant's request for relief is granted.

Please note that the final calculation of tax credits is conducted by the federal Internal Revenue Service through the reconciliation process, in accordance with section 36B(f) of the Internal Revenue code, and that decisions or interpretations of the EOHHS appeals office are not binding against the IRS during that process.

ACTION FOR THE AGENCY:

The Agency is to redetermine both the premium amount and the tax credits for the appellant only, at the time of application; and they are to provide a credit or refund to the appellant for any amounts assigned to his wife, based on those calculations. They are to remove the appellant's wife's premiums and tax credits for the months of January 2014 through November 2014. They are to insure the appellant receives a revised 1095-A. The appellant will be responsible for any bills previously assigned to Blue Cross.

Karen Walsh
Appeals Officer



APPENDIX

RULES AND REGULATIONS PERTAINING TO THE RHODE ISLAND HEALTH BENEFITS EXCHANGE

SECTION 1.0 DEFINITIONS

1.2 ***"Advance Payments of the Premium Tax Credit" or "APTCs"*** means payments of the tax credits specified in 26 USC section 36B which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan through the Exchange.

SECTION 5.3 Individuals for Whom a Premium Assistance Amount Can be Provided. An applicant will be eligible for a premium assistance amount only for a month that one or more members of the tax filer's family (the tax filer or the tax filer's spouse or tax dependent) meet the following criteria:

(a) Are enrolled in one or more QHP's; and

(b) Are not eligible for minimum essential coverage as defined in 26 CFR§1.36B-2(c) other than individual market coverage described in 5000A(f)(1)(C) of the Internal Revenue Code.

RI EOHHS MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)

1307 "MAGI" Income Eligibility Determinations

1307.01. Scope and Purpose

To implement the federal Affordable Care Act (ACA), Rhode Island took the option under the law to establish its own new web-based eligibility system with the capacity to determine whether an individual or family qualifies for affordable health care coverage paid for by Medicaid or in whole or in part by federal tax credits or other subsidies. The Executive Office of Health and Human Services (EOHHS), the Medicaid Single State Agency, and the recently established Rhode Island Health Benefits Exchange, known as HealthSourceRI (HSRI), are using this new eligibility system to make determinations for all forms of affordable coverage available under the ACA, including Medicaid.

One of the principal goals of the ACA is to improve access to affordable coverage by simplifying and streamlining the application and eligibility determination process. Toward this end, the Act established a distinct income standard – Modified Adjusted Gross Income or MAGI – to determine eligibility for affordable coverage across payers (e.g., Medicaid, tax credits, state subsidies, employers) and populations (families, pregnant women, children, adults without children). Effective January 1, 2014, the MAGI standard will be used to determine eligibility for all new applicants for Medicaid coverage in the Medicaid Affordable Care Coverage (MACC) groups identified in section 1301 of the Medicaid Code of Administrative Rules (MCAR). The process for applying for Medicaid affordable coverage using the new eligibility system is located in MCAR section 1303.

The purpose of this rule is to: describe the MAGI and explain how it will be applied; and establish the role and responsibilities of the Medicaid agency and consumers when determining MAGI related eligibility.

0110 COMPLAINTS AND HEARINGS

0110.20 DEFINITION OF AN APPEAL

REV: 08/2013

An "appeal" means a request by a claimant (or his/her authorized representative) for an opportunity to present his/her case to the appropriate state agency authority for resolution of the pertinent matter. The appeal must be filed within:

o Ten (10) days from the mail date if it pertains to General Public Assistance;
o Ninety (90) days from the mail date related to SNAP benefits;
o Forty-five (45) days from the mail date related to Office of Rehabilitation Services matters;
o Thirty (30) days from the mail date related to child support services;
o Thirty (30) days from the mail date related to the State Medical Assistance (Medicaid) Program;
o DCYF: Thirty (30) days from the mail date for any DCYF-related matter;
o BHDDH: Thirty (30) days from the mail date for any BHDDH-related matter;
o Thirty (30) days from the mail date for any other DHS program;
o Thirty (30) days from the mail date for any RIHBE-administered program.

Appeal requests for any of the programs listed above may be submitted:

· In person to any DHS/DCYF/BHDDH field office/appeals office, as appropriate; and

· By U.S. Mail to any DHS/DCYF/BHDDH field office/appeals office, as appropriate.

Appeal requests related to the MAGI Medicaid Program or related to any program administered by the RIHBE may, in addition to the submission methods listed above, be submitted:

· by telephone to the RIHBE contact center;

· by fax to the RIHBE contact center/appeals office;

· by U.S. Mail to the address indicated on the appeals request form or

· online by accessing the user's account through the website made available by the RIHBE allowing for the electronic submission of appeals.

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.