STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
APPEALS OFFICE

[redacted]

v.

Rhode Island Department of Human Services

DOCKET No. 24-3088

DECISION

I. INTRODUCTION

A telephonic hearing on the above-entitled matter was conducted by an Appeals Officer on June 3, 2024. The Appellant, [redacted] ("Appellant"), initiated this matter to appeal a decision made by the Department of Human Services ("DHS") to terminate her Medically Needy category ("ABD-Flex Medicaid") benefits. It is the position of DHS that the termination was correct because the Appellant did not submit a new application and medical bills to renew her six (6) month ABD-Flex Medicaid benefits. She disagrees with the decision and filed this appeal seeking relief from DHS in the form coverage for the month of May 2024 ongoing. For the reasons discussed in more detail below, the Appellant's appeal is granted.

II. JURISDICTION

The Executive Office of Health and Human Services ("EOHHS") is authorized and designated by R.I.G.L. §42-7.2-6.1 and EOHHS regulation 210-RICR-10-05-2 to be the principal entity responsible for appeals and hearings related to DHS programs. The administrative hearing was held in accordance with the Administrative Procedures Act, R.I.G.L. §42-35-1 et. seq. and EOHHS regulation 210-RICR-10-05-2.

III. ISSUE

The issue is whether the termination of ABD-Flex Medicaid benefits was done in compliance with Federal and State policy.

IV. STANDARD OF PROOF

It is well settled that in formal or informal adjudications modeled on the Federal Administrative Procedures Act, unless otherwise specified, a preponderance of evidence is generally required to prevail. (2 Richard J. Pierce, Administrative Law Treaties §10.7(2002) & see *Lyons v. Rhode Island Pub. Employees Council 94,* 559 A.2d 130, 134 (R.I. 1989)) (preponderance is the "normal" standard in civil cases). This means that for each element to be proven, the factfinder must believe that the facts asserted by the proponent are more probably true than false. When there is no direct evidence on a particular issue, a fair preponderance of the evidence may be supported by circumstantial evidence. (*Narragansett Electric Co. vs. Carbone,* 898 A2d 87 (R.I. 2006)).

V. PARTIES AND EXHIBITS

Present for the Agency was Glenda Ramos, Eligibility Technician III, (ETIII), who presented testimony regarding the case. DHS offered the following evidence, with no objections, which were entered into the record of hearing:

- DHS Exhibit #1- Benefit Decision Notice ("BDN") dated April 19, 2024.
- DHS Exhibit #2- Eligibility Determination Results showing ABD-Flex Medicaid benefits for months January 2020 through August 2024.

The Appellant appeared for the Hearing. She submitted the following evidence:

- Appellant Exhibit #3- Typed narrative of her version of events.
- Appellant Exhibit #4- BDN dated April 29, 2024.

- Appellant Exhibit #5- a copy of her June 4, 2024, application for ABD-Flex Medicaid and all verifications that were submitted with it.

VI. RELEVANT LAW/REGULATIONS

The ACA Expansion for Adults ("ACA Expansion") pathway provides coverage for citizens and qualified non-citizens, who are nineteen (19) to sixty-four (64) years of age and are not otherwise eligible for, or enrolled in, Medicare or Medicaid under any other State plan or Section 1115 waiver group. 210-RICR-30-00-1.5(A)(1)(f).

There are currently multiple Medicaid coverage groups that are not subject to the MAGI eligibility guidelines. Eligibility for adults who are nineteen (19) years of age and older, who are not subject to the MAGI standards, include low-income elders aged sixty-five years of age and older and adults with disabilities (known as Elderly, Aged, or Disabled ("EAD") Medicaid). These individuals are between nineteen (19) and sixty-four (64), with income up to one hundred percent (100%) of the Federal Poverty Limit ("FPL"), who do not qualify for SSI and are eligible for or enrolled in Medicare. 210-RICR-30-00-1.5(C)(2).

If an individual has an income over one hundred percent (100%) of the FPL, they can qualify for ABD-Flex (210-RICR-40-00-3.1.7(A)(4)). In this case, an individual needs to spend-down the Medically Needy Income Limit ("MNIL") before they can be covered by Medicaid (210-RICR-40-00-3.1-7(A)(3)). A spend-down is based on a six (6) month period (210-RICR-40-005.2.2(A)(1)). The spend-down is the individual's anticipated income for the six (6) month period, after a twenty-dollar ($20.00) monthly disregard (210-RICR-40-00-3.3.2(A)(2)), less six (6) times the MNIL (210-RICR-40-05-2.3(A)). The remaining amount constitutes the spend-down. To be eligible for Medicaid under ABD-Flex, the individual will need medical expenses that amount to the spend-down amount in order to be eligible. 210-RICR-40-05-2.2(A)(2).

210-RICR-40-00-2.7.2(A)(3)(b) states, in part, "At least ten (10) days prior to the renewal date, Medicaid beneficiaries are provided with a notice stating the outcome of the renewal process and explaining the basis for the Agency action- continuation or termination of eligibility…..Beneficiaries are also notified that they have a right to have their health coverage continued while awaiting a hearing if an appeal is filed within ten (10) days from the date from the date the renewal notice is received. The date the notice is received is presumed to be five (5) days from the date of the notice.

VII. FINDINGS OF FACT

1. The Appellant received a Benefit Decision Notice dated April 29, 2024, notifying her that her ABD-Flex Medicaid was closing effective May 1, 2024, because the six- month spend down period had ended.
2. The Appellant filed for an appeal nine (9) days later on May 8, 2024, because the notice of adverse action was not sent to her in a timely manner. On her appeal request, she requested aid pending. She testified that she did not receive the notice in the mail until after the closure, and she needed time to complete a new application and gather her medical expense verifications.
3. The Appellant filed a new application on June 3, 2024, and submitted all of her verifications with the new application.
4. A DHS representative spoke with the Appellant on June 18, 2024. The representative updated all of her information, read to her the rights and responsibilities, and advised her that DHS would need to wait for the results of the asset verification, and her new spend down amount was going to be $4444.00.
5. The request for aid pending was made within the regulatory timeframes for it to be granted, however, the Agency was unable to answer why aid pending had not been granted.

VIII. DISCUSSION

A recipient who is in the ABD-Flex Medicaid category must submit a new application and medical expense verifications every six (6) months. The Appellant had been assigned to the ABD-Flex Medicaid category approximately four (4) months prior to the declaration of the Public Health Emergency ("PHE") caused by the COVID-19 pandemic, and therefore had never had to recertify because all recertifications were postponed until the winding down of the PHE. While the Appellant did receive a notice that her case was closing, it was sent to the Appellant only two days prior to the closure of her ABD-Flex Medicaid, so the Appellant did not receive the notice after the closure and therefore was not afforded adequate notice of adverse action per the regulations.

The Appellant was entitled to aid pending because she made a timely request to continue her benefits when she filed her appeal request within ten (10) days, but it was not granted. The Agency representative was unable to provide a reason why the aid pending was not granted.

IX. CONCLUSION OF LAW

After careful consideration of the testimony and evidence presented at the Administrative Hearing, it is concluded that:

1. DHS did not comply with the appropriate regnlations for giving adequate notice of an adverse action, i.e., the termination of her ABD-Flex Medicaid.
2. Per State and Federal regulations, the appeal was filed within the regulatory timeframe gnidelines which require an appeal within thirty (30) days of the contested action plus five (5) days after the mailing date of the notice. Her request for aid pending was made within ten (10) days of receiving the notice and therefore was within the timeframe to grant her aid pending.
3. There was no clear reason given by the Agency why the Appellant was not granted aid pending.

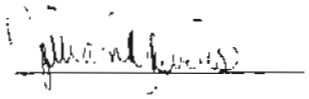
X. DECISION

Based on the foregoing Findings of Fact, Conclusions of Law, evidence, and testimony it is found that a final order be entered that DHS did not comply with the requirements of the applicable regulations and policy for termination of the Appellant's ABD-Flex Medicaid.

APPEAL GRANTED

ACTION FOR DHS

Within thirty (30) days of the decision, DHS is to re-open the Appellant's ABD-Flex case back to the date of closure, May 1, 2024. Per agreement of the parties, DHS will then render a decision on the Appellant's June 18, 2024, application in accordance with Medicaid regulations. The Appellant retains the right to appeal that subsequent DHS decision.



Jillian R. Rivers

Appeals Officer

NOTICE OF APPELLANT 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.

CERTIFICATION

I hereby certify that I mailed, via regular mail, postage prepaid, a true copy of the foregoing to [redacted] copies were sent, via email, to DHS Representatives Glenda Ramos, DHS Appeals, and DHS.PolicyQuestions@dhs.ri.gov on this 13th day of September, 2024.