BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL BY THE COMMISSIONER OF HEALTH AND SOCIAL SERVICES

In the Matter of	)	
	)	
S B	)	OAH No. 18-0876-MDE
	)	Agency No.

DECISION

I. Introduction

S B was receiving Medicaid benefits. He was notified in July 2018 that those benefits were terminated. Mr. B requested a hearing in response to that notice because he thought his benefits had been terminated quite some time ago, not because he wanted to continue receiving Medicaid.

The Division of Public Assistance (Division) notified Mr. B that he was not entitled to a hearing because it had not taken an adverse action affecting his Medicaid benefits. Mr. B then appealed that determination. Mr. B's hearing was held on September 17, 2018. Mr. B attended the hearing in person, representing himself and testifying on his own behalf. Sally Dial, a Public Assistance Analyst employed by the Division, attended the hearing telephonically and represented the Division.

The evidence in the hearing established that the Division "rolled over" Mr. B's Medicaid benefits, providing them on a continuing basis without complying with federal requirements that Mr. B be notified either that the benefits would renew or that he needed to submit a renewal application himself. This provision of ongoing benefits was made despite Mr. B notifying the Division in January 2017 that he was no longer financially qualified for Medicaid. Mr. B therefore thought he was no longer receiving Medicaid and applied for and obtained private medical insurance with a premium tax credit through the Federal Health Insurance Marketplace. Mr. B is legitimately concerned that he may have financial liability because he obtained subsidized insurance when, unbeknownst to him, he had Medicaid coverage. However, there is no affirmative relief available to Mr. B in this forum, and the Division's non-referral of Mr. B's hearing request is upheld. Should questions be raised relating to his Affordable Care Act insurance, he can use this decision to show that his Medicaid coverage was due to a government error that was neither foreseeable nor visible to him.

II. Facts

Mr. B applied for Medicaid benefits on January 29, 2016. He was then approved for Medicaid benefits, in the Medicaid Expansion Group coverage category, through the end of December 2016.[1] Mr. B subsequently notified the Division in writing on January 27, 2017 that he had applied for pension benefits and would be over income for Medicaid benefits.[2]

The Division took no action on Mr. B's January 27, 2017 correspondence where he reported a change in his income. Mr. B thought his Medicaid case had been closed, and as a responsible citizen he applied for and received private medical insurance through the Federal Health Insurance Marketplace, where he received a premium tax credit.[3]

The Division did not terminate Mr. B's Medicaid benefits. It is undisputed that it "rolled over" his Medicaid coverage through the rest of 2017, and again at the beginning of 2018, providing him with coverage without either requiring him to submit a renewal application or notifying him that the benefits would be renewed.[4]

The Division notified Mr. B on July 19, 2018 that his Medicaid benefits would be terminated at the end of July 2018.[5] The Division received a hearing request from Mr. B on August 9, 2018. The hearing request reads: "[m]y eligibility should have ended January 1, 2017, State of Alaska practices do not conform with federal requirements."[6]

The Division then opted to not refer this case to the Office of Administrative Hearings (OAH). The Division's reasoning was that because Mr. B's Medicaid coverage could not be said to be negatively affected, he did not present a hearable case.[7]

III. Discussion

The Medicaid program has numerous coverage categories. Mr. B's coverage is through the Medicaid Expansion Group category. The federal regulations which govern the Medicaid Expansion Group explicitly require that "the eligibility of Medicaid beneficiaries . . . must be renewed once every 12 months."[8] Those same regulations provide two options for renewing eligibility. One option is to require that the recipient submit a new application contained in a renewal form provided by the state

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1 Division Exs. 1.2, 2.
2 Mr. B's Ex. 6; Mr. B's testimony.
3 Mr. B's Exs. 11 – 15.
4 Ms. Dial's statement at hearing.
5 Division Ex. 4.
6 Division Ex. 5.
7 *See* the Division's August 15, 2018 *Notice of Non Referral.*
8 42 CFR § 435.916(a)(1).

agency, which would be the Division, and the recipient would then have 30 days to submit the renewal form.[9] The alternative is for the Division to provide the recipient notice that his Medicaid coverage will be renewed. However, as part of that renewal process, the Division is required to notify a recipient of the renewal and the information that it was basing the renewal upon and the recipient is required to notify the Division if that information is inaccurate.[10]

It is undisputed that the Division did not comply with either of the two renewal options when it just "rolled over" Mr. B's Medicaid coverage. Mr. B reasonably assumed that his Medicaid coverage was terminated because he did not actively renew it, nor was he notified it would be renewed. Indeed, he had taken active steps in January 2017 to notify the Division that he was no longer financially eligible for Medicaid coverage.

Mr. B now has legitimate concerns that he has financial liability because he obtained private health insurance, with a premium tax credit, when he was also technically receiving Medicaid. However, there is no remedy available to him in this quasi-judicial forum. A Medicaid recipient is entitled to request a hearing under federal law when it believes the state agency has taken an erroneous action, including not acting promptly on "[a]n initial or subsequent decision regarding eligibility."[11] The Alaska state regulation is slightly narrower than the federal regulation. It limits hearing issues to ones where an application for benefits is denied or not acted on promptly or benefits are "suspended, terminated, or reduced."[12]

The Alaska regulations which govern these hearings limit relief to correcting coverage and benefit issuance errors:

> If the final decision is that the department action at issue was in error, the department will provide assistance retroactive to the effective date of the erroneous denial, suspension, termination, or reduction.[13]

What this means is that even though the Division did not comply with federal requirements and terminate Mr. B's Medicaid coverage because he did not seek to renew it, the Department has no remedy available to give Mr. B because there is no coverage to be reinstated or benefits to be restored. With that said, the Department recognizes that Mr. B's concerns are certainly

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9 42 CFR § 435.916(a)(3).
10 42 CFR § 435.916(a)(2).
11 42 CFR § 431.220(a)(1).
12 7 AAC 49.020.
13 7 AAC 49.210.

legitimate. The factual findings in this decision may assist him in explaining how his Health Insurance Marketplace purchase came about.

IV. Conclusion

The Division's decision not to refer this case for hearing is AFFIRMED.

Dated: October 4, 2018

Signed
Lawrence A. Pederson
Administrative Law Judge

Adoption

The undersigned, by delegation from of the Commissioner of Health and Social Services, adopts this Decision, under the authority of AS 44.64.060(e)(1), as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 24th day of October, 2018.

By: *Signed*
Name: Deborah L. Erickson
Title: Project Coordinator
Agency: Office of the Commissioner, DHSS

[This document has been modified to conform to the technical standards for publication. Names may have been changed to protect privacy.]