STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. B-01/17-18
	)	
Appeal of	)	
	)	
	)	

INTRODUCTION

Petitioner appeals the termination of her Medicaid eligibility by the Department for Children and Families ("Department"). The following facts are adduced from a hearing held February 23, 2017 and documents submitted therein.

FINDINGS OF FACT

1. Petitioner receives disability-based social security income and is a household of one for the purposes of Medicaid eligibility. Petitioner has two adult children, both attending college.

2. Petitioner submitted a review application on July 20, 2016, to determine her ongoing eligibility for Medicaid. She reported income of $2,076.00 per month in social security-based income and $164.00 per week in worker's compensation (by the time of hearing, petitioner's workers' compensation had ended).

3. By notice dated August 15, 2016, the Department notified petitioner that her Medicaid would be terminated as of August 27, 2016, because her income "is more than the rules allow." The notice included a calculation of petitioner's 6-month "spend-down" by which she could potentially become eligible for Medicaid, depending upon her out-of-pocket expenses. Petitioner's spend-down was calculated at $1,679.10 per month, for a 6-month total of $10,074.60. The notice then deducted petitioner's expected Medicare premiums, deducting $629.40 for the same 6-month period, resulting in a spend-down of $9,445.20.

4. Petitioner indicates that she contacted the Department and informed a worker on the phone that she wished to appeal the decision and also wrote a letter of appeal. For reasons that are unclear, petitioner did not receive continuing coverage (at the time) although her case was processed through an internal review of some kind and the Board did not receive her appeal until January 10, 2017, relayed by the Department. In any event, the Department ultimately acknowledged that petitioner should have received continuing coverage and by the time of hearing in this appeal had retroactively adjusted her coverage to reflect that.

5. In the meantime, after petitioner received notice that her coverage was going to be terminated at the end of August, she also made contact with numerous entities (a navigator, Vermont Health Connect, the local area agency on aging, among others) to see if she could get assistance with her health coverage. Petitioner was (and is) especially concerned about a treatment she needs for her arthritis that is billed at approximately $10,000.00 every six weeks (with only basic Medicare coverage, according to petitioner she would owe a 20 percent co-pay for this treatment).

6. Petitioner was not able to obtain financial assistance for health insurance (because she has Medicare she does not qualify for subsidies through Vermont Health Connect) and was frustrated with the lack of information provided to her. She ultimately was able to find a Medicare supplemental health insurance plan to cover her when her Medicaid ended – this has cost her $250.00 per month since September. Petitioner was not sure what portion, if any, of her Medicare co-pay this supplemental insurance covers for the arthritis treatment mentioned above.

7. Petitioner intends to continue to pay for supplemental Medicare insurance if termination of her Medicaid is affirmed.

8. Petitioner also expressed frustration at the notices from the Department, pointing out, for example, that she received a notice in October of 2016 that she is eligible for Medicaid, when in fact she was not eligible or receiving continuing benefits (although unclear, this notice may have been a result of the Department's realization that she should be receiving continuing benefits). As noted above, the Department has acknowledged that it should and will provide Medicaid coverage during this period and through the pendency of this appeal.

9. Petitioner has attempted to see whether she can "suspend" her Medicare supplemental insurance while her Medicaid benefits are continuing; whether this is feasible has been, at best, inconclusive. Petitioner was referred at hearing to speak with a healthcare advocate regarding this issue, given that it is a Medicare or private insurance question.

ORDERS

The Department's decision is affirmed.

REASONS

Review of the Department's determination is de novo. The Department has the burden of proof at hearing if terminating or reducing existing benefits; otherwise the petitioner bears the burden. *See* Fair Hearing Rule 1000.3.0.4.

Applicants receiving disability-based social security income such as SSDI or SSI – as with petitioner - are subject to the income eligibility threshold(s) under the Medicaid for the Aged, Blind and Disabled ("MABD") category. *See* Health Benefits Eligibility and Enrollment ("HBEE") Rules § 7.03(a)(5) and § 8.03(a). Petitioner's current household income of $2,076.00 per month is undisputed. After subtraction of a $20.00 disregard for unearned income, petitioner's countable income remains well over the MABD eligibility threshold of $1,108.00 for a household of one, also known as the protected income level ("PIL"). *See* HBEE Rules § 8.06(b); Medicaid Procedures Bulletin 16-36 (effective 1-1-17). It is noted that these figures reflect petitioner's reported income without the workers' compensation payments she had previously been receiving, as well as an updated PIL standard for 2017. This would appear

to affect her spend-down amount but does not affect whether she is income-eligible for Medicaid.[1]

Petitioner further argues that she is aggrieved by the Department's failure to provide continuing benefits at the time of her appeal, resulting in her obtaining supplemental insurance at a cost of $250.00 per month. She was undoubtedly frustrated by complicated healthcare circumstances and the lack of available financial assistance following her Medicaid termination, along with at least one unclear notice and an acknowledged omission by the Department. However, the Department has retroactively adjusted her Medicaid coverage to include the months between her termination and the pendency of the hearing. Petitioner now has the option (as she was advised at hearing) of having her providers bill Medicaid for any costs during this period which were not covered by Medicare or her supplemental insurance. Petitioner's decision to buy supplemental insurance is one that she made as a result of termination of her Medicaid, not as a result of the failure of the

[1] Petitioner should contact Vermont Health Connect for an updated calculation of her six-month spend-down (which appears to be above $5,000.00). At hearing, although advised that she has the option of meeting the spend-down, petitioner was only interested in achieving Medicaid eligibility without a substantial spend-down. She was not clear on whether her supplemental Medicare covered any or all of the co-pay associated with her arthritis treatment.

Department to provide continuing benefits; and, in any event, she appears to be making a claim for damages which is outside the Board's jurisdiction.

The Department's determination is otherwise consistent with the rules and must be affirmed by the Board. *See* 3 V.S.A. § 3091(d), Fair Hearing Rule No. 1000.4D.

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