STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. H-01/17-41
	)	
Appeal of	)	
	)	
	)	

INTRODUCTION

The petitioner appeals a decision of the Department for Children and Families (DCF) terminating his Medicaid benefits due to excess income.

FINDINGS OF FACTS

1. The petitioner, a fifty-three year old single able-bodied man, who was last found eligible for Medicaid for Children and Adults (MCA)on January 1, 2014 based on a qualifying income level. He duly reported all of his income increases to DCF in the intervening time.

2. The petitioner's eligibility was not reviewed again until the summer of 2016 because of strained department resources associated with the Vermont Health Connect roll out. At that time, DCF determined that the petitioner was no longer eligible for MCA due to excess income.

3. On November 29, 2016, DCF notified the petitioner that he would be terminated from MCA Medicaid on December 31, 2016 unless he filed a new application. The petitioner did so on December 6, 2016. On that application, the petitioner reported that he has $2,588.14 in monthly income.

4. On December 7, 2016, DCF notified the petitioner that he was no longer eligible for Medicaid based on excess income and that his Medicaid would terminate as of December 31, 2016. The petitioner was also told that he would receive $245.72 in Advanced Premium Tax Credit (APTC) benefits per month and $38.83 in Vermont Premium Assistance (VPA)subsidies towards the cost of a quality health plan (QHP) on the Vermont Health Connect exchange if he applied within 60 days of the Medicaid termination.

5. The petitioner appealed that decision and has received continuing benefits since that time.[1]

6. The petitioner agrees that his income is as he reported it and did not raise any further deductions that

[1]Although the petitioner requested the appeal on December 6, 2016, it was not transmitted to the Board until January 18, 2017, an unexplained delay. Thereafter, the petitioner missed his first hearing scheduled on February 6, 2016, but was allowed to re-schedule it after he claimed illness for missing the first. This appeal was finally heard on March 6, 2017. The petitioner's benefits have continued through the 3-month period involved.

might be available to him from his income under the MAGI accounting rules.[2]

7. The petitioner says that he needs Medicaid because he attends a Methadone clinic which will only accept Medicaid payments. This clinic has enabled him to manage a life-long addiction to drugs and to get and maintain gainful employment. If he must pay the cost of the medicine out of pocket it is $140.00 per week. He fears that his inability to stay connected to the clinic will mean a relapse into drug addiction and unemployment. He does not believe that there is a Methadone clinic in Vermont that will take private insurance so he does not think Vermont Health Connect can help him.

ORDER

The decision of DCF terminating the petitioner's Medicaid benefits is affirmed.

[2] MAGI income for most people is their gross income. MAGI is determined by taking the "Adjusted Gross Income" found on Line 37 of IRS from 1040 (after deductions such as self-employed retirement and IRA contributions, self-employment taxes, alimony payments, health savings accounts, student loan interest) and adding back in non-taxable social security benefits, tax exempt interest, and foreign earned income and housing expenses for Americans living Abroad (Form 2555).

REASONS

In a termination of benefits case, the burden is on the Department by a preponderance of evidence to demonstrate facts supporting its decision. Fair Hearing Rule 1000.3(O)(4). The petitioner was originally determined to be eligible for Medicaid in January of 2014 under the Medicaid for Children and Adults program because he was an adult between the ages of 19 and 65 and his income met the income requirements for a household of one. HBEE § 7.03(a)(5)(i)(A). The petitioner's income had increased significantly due to obtaining gainful employment in the last two years. His MAGI now is well in excess of the $1,387.15 maximum for a household of one.

As DCF's decision finding the petitioner ineligible for Medicaid is consistent with its regulations, the Board is bound to uphold the result. 3 V.S.A. § 3091(d), Fair Hearing Rule 1000.4(D). The petitioner is reminded that he has sixty days following a final decision of the Board to sign up for a quality health plan. He has been given information to make an appointment with a navigator to assist him in choosing an insurance program that will best suit his needs.

# # #