STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 10,036
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals the Department of Social Welfare's denial of her application for Medicaid transportation services.

FINDINGS OF FACT

1. The petitioner is a Medicaid recipient who lives in Brattleboro and who has been obtaining needed obstetrical services from a physician in Greenfield, Massachusetts, some twenty miles from her home since July of 1990.

2. In August of 1990, the petitioner applied through SEVCA for assistance with transportation to Greenfield because she does not drive and could not afford to hire someone to take her. She was told she could be driven to Keene, New Hampshire or Springfield, Vermont but not to Greenfield, even though that area is closer to her home and is commonly used by persons in her community to obtain medical services.

3. While she was awaiting the Department's decision and, later, appealing its denial, the petitioner was transported to Greenfield by her father who incurred some out-of-pocket expenses with regard to the trips. Because he works, he was

unable to carry on providing transportation and she was provided rides by a local mental health organization. The petitioner had her baby in Greenfield on October 20, 1990 and continues to go to Greenfield for post-delivery care.

4. Prior to becoming a patient in Greenfield, the petitioner was treated in Brattleboro by doctors in its only obstetrics practice. She was unhappy with the quality of care she received there and also believed she could more easily obtain a tubal ligation elsewhere since her Brattleboro doctor was reluctant to perform one due to her age (20), even though she already had two children.

5. In addition to the proposed fact-finding above, the parties have stipulated to the inclusion of all relevant facts found in Fair Hearing No. 10,060 and to the following facts:

ORDER

The Department's decision is reversed.

REASONS

The facts in this matter are very close to those in Fair Hearing No. 10,060 and the legal issues are identical. The reasoning in that opinion, which is attached hereto, is therefore, adopted as the rationale for this opinion.

One further issue arose in the course of this hearing regarding the petitioner's ability to recover for any expenses she may have already incurred for transportation to Greenfield, since by regulation, the Department

generally covers Medicaid related services by paying the providers of the services itself rather than reimbursing individuals. See generally M ∋ 150 et seq.

The regulations, however, make a specific exception to that policy in the following circumstances:

Medical Services

> The Department pays providers for Medicaid Services through a fiscal agent. To receive payment, the provider must send a claim to the fiscal agent subject to the limitations and conditions specified in Sections M154-M159.
>
> The Department will reimburse a Medicaid recipient for his/her out-of-pocket expense for covered medical services under the following conditions only:
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> > The recipient applied for benefits after February 15, 1973, and was denied; and
> >
> > The recipient was later granted Medicaid as a result of any review of the initial denial which resulted in its reversal (e.g. quality control review, supervisory review, SSI appeal, appeal and reversal by the Human Services Board, or any other identification of an error in the original determination which results in its reversal).
>
> Reimbursement is for 100 percent of the out-of-pocket expenditures made by a recipient, for Medicaid-covered services provided between the date of eligibility (which may be as early as the first day of the third month before the month of application) and the date the recipient's first Medicaid ID was made available to him/her (when this date cannot be determined otherwise, use the second mail delivery day following the date the first Medicaid ID was mailed).
>
> Payment cannot otherwise be made direct to a Medicaid recipient, even if he/she has already paid the provider for a covered service. When Medicaid coverage is granted after bills have been paid (for example, through application for retroactive coverage), the recipient may ask the provider to bill Medicaid and refund the recipient's payment. If the provider agrees to do so, he/she must accept the Medicaid allowance and refund the full amount of the

recipient's payment (see also section M154).

The fiscal agent sends a notice of Medicaid benefits paid to a sample of recipients who receive a service each month. The recipient must report any disagreement with the notice to the Department.

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This regulation, then, would require the Department to reimburse the petitioner for 100% of the out-of-pocket expenditures made by the recipient from the time she first requested this service until it was resolved in her favor. Under this rule, then, the petitioner can be directly reimbursed for any expenses she can prove she made in connection with getting to Greenfield. Common sense and fairness would also include expenditures actually made by other members of her family on her behalf since they were essentially loans to her to obtain the services she should have been getting from Medicaid. There seems to be no provision for reimbursing another health organization which provided the services to the petitioner at no cost (such as a mental health agency). That policy is consistent with the Medicaid maximum that the program is the provider of last resort.

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