STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 9856 et al.
	)	
	)	
Appeal of	)	

INTRODUCTION

These cases concern Motions to Dismiss filed by the Department of Social Welfare in certain medicaid disability appeals. The issues are esoteric and complex. They involve the validity of recent amendments to the federal and state medicaid regulations making federal Supplemental Security Income (SSI) disability determinations binding on states for purposes of medicaid.

BACKGROUND

In each case under consideration herein the petitioner has applied for medicaid benefits based on disability. Each petitioner has also applied for and has been denied SSI disability benefits by the Social Security Administration (SSA) at either the initial decision level or some level of the SSA appeal process.

Prior to April 1, 1990, all individuals who had been denied medicaid disability benefits could (and many certainly did) appeal to the Human Services Board for a de novo review of their cases. The "boiler plate" issue beforethe Board in all those cases was whether the individual was "disabled within the meaning of the pertinent regulations." Even though

the Department's definition of disability for medicaid is in all respects identical to the federal SSI disability regulations,[1] the Department never maintained that the Board was bound, and the Board never considered itself bound, by any disability findings or decisions by SSA. Appeals concerning SSI benefits were (and still are) handled exclusively through federal SSA processes.[2]

Effective April 1, 1990, the federal and state medicaid regulations were amended to make the decision of SSA with regard to the issue of disability in SSI cases binding on state medicaid agencies (see infra).[3] This not only made SSA responsible in these cases for the initial medicaid decision, but also terminated the right of this category of medicaid applicants to a separate state administrative appeal on the issue of disability. The amended regulations provide that these individuals must now pursue any and all appeals concerning disability through the federal SSA appeals process. As a result, a medicaid applicant who also applies for SSI benefits cannot under the amended regulations be found eligible for medicaid unless and until SSA finds him or her disabled for purposes of SSI. (Under the regulations, states are still responsible for determining disability for medicaid applicants who do not apply for SSI or who have been determined ineligible for that program for reasons other than disability. Thus, even

if the amended regulations at issue here are upheld, the Department and the Board will still determine the disability claims of medicaid applicants in these circumstances. See infra.)

In Vermont, all medicaid disability applications are initially determined by Disability Determination Services (DDS), a division of the Department of Social and Rehabilitation Services, under a contractual arrangement with the Department of Social Welfare. However, DDS also has a contractual arrangement with SSA to render initial and reconsidered disability determinations for Vermont residents applying for Social Security (OASDI) or SSI benefits. Thus, as a practical matter, a person in this state who has applied for both SSI and medicaid has always received the same initial determination from the Department and SSA regarding disability (assuming the applications are more or less concurrent and involve the same medical evidence). Although each agency sends out a separate notice of the DDS decision, the Department's initial medicaid determination has never differed from SSA's initial (or "reconsidered") SSI determination.

The Department, however, is now moving to dismiss the Human Services Board appeals of all medicaid applicants who have been determined ineligible for SSI by DDS, as agent for the Social Security Administration.

ORDER

The Department's Motions to Dismiss are denied and the matters shall be scheduled forthwith for de novo hearings on the issue of disability.

REASONS

The amended federal regulation 42 C.F.R. э 435.541 provides in pertinent part:

> Determinations of disability.
>
> (a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
>
> > (1) If the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act,[4] the agency may not make a determination of disability when the only application is filed with SSA.
> >
> > (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in э 435.911 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under э 435.909.
>
> (b) Effect of SSA determinations. (1) except in the circumstances specified in paragraph (c)(3) of this section--
>
> > (i) An SSA disability determination is binding on an agency until the determination is changed by SSA.
> >
> > (ii) If the SSA determination is changed, the new determination is also binding on the agency.
> >
> > (2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based

upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

(1) The individual applies for Medicaid as a non-cash recipient and has not applied to SSA for SSI cash benefits, whether or not a State has a section 1634 agreement with SSA; or an individual applies for Medicaid and has applied to SSA for SSI benefits and is found ineligible for SSI for a reason other than disability.

(2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid.

(3) The individual applies to SSA for SSI and to the State Medicaid agency for Medicaid, the State does not have a section 1634 agreement with SSA, and either the State uses more restrictive criteria than SSI for determining Medicaid eligibility under its section 1902(f) option or, in the case of a State that uses SSI criteria, SSA has not made an SSI disability determination in time for the State to comply with the Medicaid time limit for making a prompt determination on an individual's application for Medicaid.

(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA, and--

(i) Alleges a disabling condition different from, or in addition to, that consideration by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and--

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

. . .

In accordance with the above, the Department has adopted the following provisions in its medicaid regulations:

M211 Relationship to SSI - Aged, Blind or Disabled

An applicant for Medicaid must establish his/her categorical relationship to SSI by meeting one of the following requirements:

(1) 65 years of age or over; or

(2) blindness as determined by the state's disability determination agent, or by the receipt of Social Security Disability benefits (NOTE: former recipients of SSI/AABD or OASDI whose assistance had been based on blindness and whose benefits have been terminated for any reason other than "no longer blind", may be considered blind for the purposes of SSI-related Medicaid for up to one year from the date of termination); or

(3) disability as determined by the state's disability determination agent, or by the receipt of Social Security Disability benefits (NOTE: former recipients of SSI/AABD or OASDI whose assistance had been based on disability and whose benefits have been terminated for any reason other than "no longer disabled", may be considered disabled

for the purposes of SSI-related Medicaid for up to one year from the date of termination).

The state's disability determination agent makes the disability determination in the following circumstances:

- the individual has not applied for SSI/AABD or the individual has applied for SSI/AABD and was found ineligible for a reason other than disability, or

- the individual has applied for SSI/AABD and SSA has not made a disability determination within 90 days from the date of the individual's application for Medicaid, or

- the individual alleges a disabling condition different from, or in addition to, that considered by SSA, or

- the individual alleges more than 12 months after the most recent SSA determination of "not disabled" that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations, or

- alleges fewer than 12 months after the most recent SSA determination of "not disabled" that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and

  - has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

  - he or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid.

M142 Right to Appeal

Any Medicaid applicant or recipient has a right to appeal any decision of the Department about his or her Medicaid eligibility or amount of coverage, and to request a fair hearing before the Human Services Board (see Section M144) with the following exception. An applicant for or recipient of Supplemental Security Income (SSI/AABD) benefits who is denied SSI/AABD benefits or has his/her SSI/AABD benefits terminated because the Social Security Administration (SSA) or its agent found him/her to be not disabled, may not appeal the Medicaid denial or termination that results from this action by the SSA or its agent to the Human Services Board (see Disability Determination Appeal below). . .

M142.1 Disability Determination Appeal

(1) Social Security Administration (SSA) Disability Decision - except when the Department has made the disability determination (see below),

- an SSA disability determination is binding on the Department until the determination is changed by SSA and may not be appealed through the Department's appeal process. However, when an individual who has been found "not disabled" by the SSA meets the requirements specified in M211, he or she, though not entitled to an appeal of the SSA determination through the Department's appeal process, is entitled to a separate state determination of disability for the purposes of determining his or her eligibility for Medicaid.

- the Department must refer all applicants who do not meet the requirements specified in M211 for a separate state determination of disability and who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability, to SSA for reconsideration or reopening of the determination.

(2) Department Disability Decision - if the state's disability determination agent has made a Medicaid disability determination under the circumstances specified in Relationship to SSI - Aged, Blind or Disabled, the decision may be appealed to the Human Services Board.

The primary issue raised by the above amendments to the regulations is: If an SSI/medicaid applicant appeals the

initial DDS/SSA disability determination, are the Department and the Board precluded from all further consideration of the issue of disability? Clearly, the amended regulations (supra) answer this question in the affirmative. The Board concludes, however, that, in so doing, the regulations impermissibly alter a statutory definition of medicaid eligibility and deprive certain medicaid applicants of their statutory and due process rights to an administrative appeal hearing before the state medicaid agency.

The federal Medicaid statutes, at 42 U.S.C. э 1396a(a)(10)(A), include the provision that states must make Medicaid benefits "available" to the following persons:

> (i) all individuals receiving aid or assistance under any plan of the state approved under Subchapter I, X, XIV, or XVI of this chapter, or part A or part E of Subchapter IV of this chapter . . . , or with respect to whom supplemental security income benefits are being paid under Subchapter XVI or this chapter; and
>
> (ii) at the option of the State, to any group or groups of individuals described in section 1396(a) of this title . . . who are not individuals described in clause (i)of this subparagraph but--(I) who meet the income and resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be). . .

Clause (i) of the above sets forth the so-called "mandatory" medicaid eligibility criteria--e.g. the receipt of ANFC ("part A of Subchapter IV") or SSI ("Subchapter XVI") benefits. Under this section, people receiving SSI are automatically "categorically eligible" for medicaid. Clause (ii), above, sets forth the so-called "optional categories" of medicaid assistance, which states may or may

not elect to cover. 42 U.S.C. э 1396d(a) (referred to in clause (ii), above) defines these optional categories to include:

> . . . individuals . . . with respect to whom supplemental security income benefits are not being paid under Subchapter XVI of this chapter, who are--
>
> . . .
>
> (vii) blind or disabled as defined in section 1382c of this title. . .

Vermont is one of many states that elects to provide medicaid benefits to the above "category" of individuals.

Under the above provision, a needy individual is eligible for medicaid if he is not receiving (i.e., "being paid") SSI benefits and if he is disabled according to the criteria of the SSI program (section 1382c, referred to above, is the SSI statutory definition of disability). The statute does not define this category of eligibility for medicaid in terms of being disabled as determined by SSA. Although other statutes authorize SSA in some instances--and strictly at the option of states (see infra)--to make medicaid eligibility decisions for individuals applying for SSI (see 42 U.S.C. ээ 1396a(a)(5) and 1383c[5]) nothing in any of the statutes provides or intimates that SSA's authority and jurisdiction in any medicaid case extends beyond the initial disability determination process.

42 U.S.C. э 1396a(a)(3) provides that state Medicaid plans shall:

> Provide for granting an opportunity for a fair hearing

> before the state agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness. (Emphasis added.)

Nowhere in the statutes is it stated or implied that this right to a state hearing is limited as to any aspect of medicaid eligibility. The Board concludes that if Congress had intended every state's medicaid agency to be bound in every respect by SSA disability determinations, and certain individuals (i.e., SSI applicants) to not be entitled to a state medicaid hearing on the issue of disability, it could have plainly and easily said so. Since it has not, the plain language of 42 U.S.C. ээ 1396a(a)(3) and 1396d(a)(vii)(supra) should be controlling.

Apparently, even before the amended regulations went into effect the federal agency required some states to follow a "policy" of adhering to SSA determinations of disability.[6] In the case of Rousseau v. Bordeleau, 624 F Supp. 355 (1985) the Federal District Court for Rhode Island held this policy to be violative of the statute and regulations in effect at that time. Although the part of the Rousseau opinion based on the Court's interpretation of the federal regulations is effectively negated by the recent amendments (which clearly adopt the "policy" at issue in Rousseau), the Court also held the policy to be contrary to the federal statute and to the plaintiffs' due process rights. At page 361 of its opinion the Court wrote:

> The Medical Assistance statute and regulations provide the framework for appealing denials of claims. 42

> U.S.C. ∋ 1396a(a)(3); 42 C.F.R, 431.200. The regulations provide for an evidentiary hearing, 42 C.F.R. 431.205(b) as well as the requirement that the "hearing system meet the due process standards set forth in Goldberg v. Kelly, 397 U.S. 254[90 S.Ct. 1011, 25 L.Ed.2d 287] (1970)" . . . . 42 C.F.R. 431.205(d). A meaningful hearing would not be afforded an applicant for Medicaid if the only issue is whether or not the applicant's SSI application had been denied. The statute and regulations require that applications for Medical Assistance be reviewed independently of any denial action made by the Social Security Administration. A fair hearing process requires not only an independent review of an applicant's claim of disability but also the possibility of a result different from the federal determination.
>
> Congress has spoken through the statute that a State participating in the Medical Assistance Program is to determine eligibility. If a change is to be made, it is Congress's right and responsibility to change the statute. Although the present procedure with both state and federal determinations involves two separate determinations which may result in inconsistent outcomes, this Court does not have the authority to legislate and to change the statute. (Emphasis added.)

In its published comments preceding the notice of the amended regulations in question (Federal Register, Vol. 54, No. 236, December 11, 1989, p 50755) the federal agency specifically addressed the Rousseau decision, stating (at p 50755):

> We do not agree with this decision for two reasons. First the decision in the Rousseau case was in part the result of a lack of clarity in the regulations which these final regulations will correct. Once these final regulations are in effect, the regulations relied upon by the court in support of its decision will have been changed and a reevaluation of the Rousseau decision would be in order. Secondly, we believe the statutory analysis in Rousseau is weak because the Court failed to distinguish between determining eligibility and determining disability. It is only the determination of disability that is affected by this regulation.

The Board finds both aspects of the agency's critique of Rousseau flawed. First, even though Rousseau was in part

based on provisions in the regulations that have now been amended (admittedly, there is no longer any question as to the agency's intent), the Court's analysis is based largely on statutory and due process considerations. The Rousseau Court's holding that the federal and state agencies lack "the authority to legislate and to change the statute" is, of course, consistent with already-well-established case law. See Mohasco Corporation v. Silver, 447 US 807,825 (1980); In Re Peel Gallery, 149 VT 348(1988).

Thus, the mere fact that the federal agency has now amended its regulations to conform with its earlier "policy" does not, in and of itself, negate the Rousseau Court's holding.

Secondly, the federal agency in its comments either is being disingenuous or is simply mistaken in its assertion that "only the determination of disability . . . (not) . . . eligibility" is affected by the amendments. Disability is the core of eligibility for medicaid under 42 U.S.C. э 1396d(a)(vii). As noted above, that section defines eligibility as being "disabled" according to SSI criteria--not according to the determination of SSA. By effectively changing the definition from "disabled according to SSI criteria" to "disabled as determined by SSA", and by denying SSI applicants the right to a state-level appeal of this aspect of their medicaid decisions, the regulations significantly alter and restrict basic statutory provisions regarding eligibility and due process. As the Rousseau Court correctly held, this exceeds the scope of the agency's

authority.

The Board is aware of two more-recent (though, also, pre-amendment) federal court decisions that disagreed with Rousseau. One, Fratone v. Division of Public Welfare of N.J. Department of Human Services, D.N.J., Nos. 87-2569, February 8, 1988, expressly upheld the same agency "policy" that was at issue in Rousseau. In the Board's opinion, however, the Fratone Court placed undue emphasis on the agency's regulatory definitions of medicaid eligibility and did not adequately analyze the federal statutes.

The Fratone Court, quoting portions of only the federal regulations, correctly observed that "once a medicaid applicant has been held ineligible for SSI benefits by (SSA), it is simply impossible to describe that person as an individual who would be eligible for . . . SSI." The problem with the above analysis, however, is that the federal statute does not define medicaid eligibility in terms of one who "would be eligible for SSI." As noted above, it states only that an individual be "disabled" according to SSI criteria (and that the individual not be receiving SSI benefits). Either unaware of or ignoring this subtlety, the Fratone Court found the federal policy to be consistent with Congressional intent. As noted above and below, however, the Board finds nothing, either express or implied, in the language of the federal statute evincing such intent.

Relying heavily on Fratone, the Eighth Circuit Federal Court of Appeals (in a 2-1 decision with the Chief Judge dissenting) reversed an Iowa Federal District Court's decision that had essentially adopted the reasoning in Rousseau. Armstrong v. Palmer, 879 F2D 437 (1989). Curiously, however, the plaintiff in Armstrong "(did) not assert a constitutional or statutory challenge to the regulations." Id. at p. 440. Thus, that Court did not examine the issue in light of either the definitions of eligibility in the federal statute or the plaintiff's statutory and due process rights to a hearing. Instead it relied almost exclusively, as did Fratone, on the agency's regulations. In the Board's view, since neither Fratone nor Armstrong considers the agency's policy vis-a-vis the statutory definition of eligibility and right to a state hearing, the fact that the agency has now promulgated regulations implementing the policy at issue in those cases does little, if anything, to strengthen those opinions.

The Court in Armstrong, curiously in that it expressly did not consider the statutes underlying the agency's regulations, nonetheless concluded that the agency's policy "furthers Congress's desire to avoid spending limited benefit funds 'to duplicate . . . the eligibility work already being carried on by the federal agency'". Id. at p. 440. The legislative history cited by Armstrong, H.R. Rep. (1971), reprinted in 1972 U.S. Code Congress and Admin. News, 4989, 5182, pertains to 43 U.S.C. э 1383c under which

states are permitted to enter into "agreements" with SSA for that agency to "determine eligibility for medical assistance" in cases of individuals who are eligible for SSI.[7] As the regulations themselves acknowledge, however (see 42 C.F.R. э 435.541(c)(1) and (3), supra), 42 U.S.C. э 1383c is not binding on states, and not every state has entered into such an "agreement" with SSA. Thus, the Board finds the legislative history cited by Armstrong (supra) unpersuasive as a general statement of Congressional intent regarding every state's medicaid decision-making process. It is even less persuasive as an indication of intent regarding any state's appeals processes (whether or not that state has entered into an agreement with SSA pursuant to э1383c).

Indeed, the very fact that 42 U.S.C. э 1383c and 42 U.S.C. э 1396a(a)(5) (see supra) establish various methods for states at their option to determine disability for medicaid is a strong indication that Congress was not at all concerned about "inconsistent" state and federal disability determinations. In fact, it can be argued that Congress, in enacting 42 U.S.C. ээ 1383c and 1396a(a)(5) specifically condoned, if not encouraged, states to make independent disability determinations for medicaid. This view is supported by the recent case of Perea v. Sullivan, U.S.D.C. Utah, No. 87-NC-0076, (November 29, 1989, Reconsidered decision May 24, 1990). The Perea Court held that in a

state (like Utah) that has not "delegated" disability determinations to SSA (under 42 U.S.C. ээ 1396a(a)(5) or 1383c) the newly-enacted regulation compelling the state agency to adopt the disability decisions of SSA "constitutes an unreasonable interpretation in contravention of the (federal) statute."

The same reasoning is even more applicable to the right to a state appeal required by 42 U.S.C. э 1396a(a)(3)--which, in the Board's view, is not at all ambiguous. Nearly two decades have now passed since the comments cited in Armstrong (supra) were published, and Congress has not amended or "clarified" the medicaid statutes (supra) despite the "inconsistency" now decried by the federal agency. Whatever "intent" that can be gleaned from the legislative history cited in Armstrong is hardly manifest enough regarding the issue at hand to support looking beyond the "plain meaning" of the federal statutes (supra)that define the basic categories of medicaid eligibility and provide for a right to a state hearing. See Vermont State Employees Assn. v. State of Vermont, 151 VT 492 (1989).

However, even assuming arguendo a "general intent" by Congress to promote "uniform state treatment of Federal disability findings" (see Federal Register, id. at p. 50787), the amended regulations do little to further this goal--and, arguably, create far worse inequities. For example, the regulations address only concurrent medicaid and SSI disability claims. Medicaid applicants with

concurrent Social Security (OASDI) disability claims (even though the disability standards for OASDI are identical to SSI and medicaid, see 20 C.F.R. э 404, Subpart P) are completely unaffected by the amendments. At best, then, the amended regulations take only a partial step toward the purported goal of encouraging "uniformity" in the medicaid and SSA decision making processes.

At worst, however, they create a perverse disparity within the medicaid program that did not exist before--segregating applicants for SSI (who are, arguably, the most needy of medicaid claimants), and denying them (but not any others) the right to a state appeal of their medicaid denials. The previous system may have resulted in certain individuals receiving inconsistent state medicaid and federal SSI disability decisions. The amendments, however, will assuredly create an even more egregious inconsistency--disparate federal and state medicaid decisions based not on any differences in people's medical conditions, but based solely on their status as SSI or non-SSI applicants. The Board is at a loss to see how this change in the regulations promotes fairness and "uniformity."

There are other ways in which the amended regulations do violence to the "uniform" treatment of medicaid applicants. Although there is no question that federal law and regulations afford individuals denied SSI "numerous opportunities . . . to seek administrative and judicial review of the SSA's nondisability determination" (see

Armstrong, id. at p. 440), significant differences exist between the federal and the state appeal processes in the promptness of obtaining hearings and decisions. Under its rules the Board has 60 days to decide a medicaid appeal (unless a continuance is requested and granted). Human Services Board Rule No. 21. Admittedly, the Board is seldom, if ever, pushed by appellants to comply with this provision. Nonetheless, it creates a legal right to a decision in a manner more timely than its SSI counterpart in the federal appeals process.[8] Again, it appears perverse to view the creation of this disparity--aimed exclusively at the medicaid applicants who are likely to be the most needy--as a move toward fairness and "uniformity".

Regardless, however, of whether the amended regulations actually accomplish their purported intent, it is clear that Congress's overall purpose in expanding medicaid coverage to aged and disabled individuals who are not receiving SSI was to enable them to obtain needed medical services. 42 U.S.C. э 1396. As noted above, 42 U.S.C. э 1396d(a)(vii) refers to "disabled" individuals only in terms of SSI criteria--not in terms of an SSA determination. 42 U.S.C. э 1396a(a)(3) grants all denied medicaid applicants the right to "a fair hearing before the State agency." Nothing in the statutes limits the subject matter jurisdiction of the state appeals process. In light of this, there is no basis whatsoever to assume, much less conclude as a matter of law, that Congress

was at all concerned about the possibility of "inconsistent" disability decisions between federal SSI and state medicaid appeal tribunals. See Rousseau, id. at p. 361 (supra).

Inasmuch as the amended federal and state regulations (supra) alter and restrict the federal statutory definition of a category of medicaid eligibility, and remove from a limited class of medicaid applicants the clear and unambiguous statutory and due process rights to a fair hearing before the state agency, they must be held invalid.[9]

The Department's motions to dismiss in these matters are, therefore, denied.[10] 3 V.S.A. ээ 3091(d); Fair hearing No. 19.

FOOTNOTES

[1]See Medicaid Manual ээ 211.2 and 211.4 and 20 C.F.R. ээ 416.900 et seq.

[2]See 20 C.F.R. э 416.1429 et seq.

[3]Actually, the effective date of the federal regulations was January 10, 1990. The Department apparently did not amend its regulations to reflect the federal changes until April 1, 1990.

[4]It appears that the Department has such an agreement (commonly referred to as "section 1634 agreements") with SSA. See 42 U.S.C. э 1383c, footnote 5, infra.

[5]42 U.S.C. э 1396a(a)(5) provides that a state medicaid plan must:

> "Either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of

eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI of this chapter (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter."

42 U.S.C. э 1383c provides:

"The Secretary may enter into an agreement with any State which wishes to do so under which he will determine eligibility for medical assistance in the case of aged, blind, or disabled individuals under such State's plan approved under subchapter XIX of this chapter. Any such agreement shall provide for payments by the State, for use by the Secretary in carrying out the agreement, of an amount equal to one-half of the cost of carrying out the agreement, but in computing such cost with respect to individuals eligible for benefits under this subchapter, the Secretary shall include only those costs which are additional to the costs incurred in carrying out this subchapter."

[6]The Board does not know why the federal agency never disapproved of Vermont's hearing procedures that, up until now, afforded de novo state hearings to all medicaid applicants.

[7]See footnotes 4 and 5, supra.

[8]The Board understands the "guideline" (i.e., court-imposed) time limit for SSI-disability appeal decisions to be 120 days. The regulations, themselves, impose no time limits. See 20 C.F.R. э 416.1453(b)(1)(i).

[9]The regulations in question here are readily distinguished from those that previously defined an ANFC "unemployed parent" as one who has not been "deregistered" from a work and training program by another agency (i.e., the Department of Employment and Training (DET)). See previous W.A.M. э 2333.1(7). In those cases, the Board ruled that it was bound by and did not have jurisdiction to consider the decision by DET, which, in effect, determined the entire family's eligibility for ANFC. See Fair Hearings No. 8351 and 5175. This was because the federal and state

ANFC regulations regarding DET WIN determinations implemented a clear and unequivocal definition of ANFC eligibility set forth in the federal statutes. See previous 42 U.S.C. э 602(a)(19). In the instant case, it is the fact that the regulations in question alter and restrict the federal statutory definitions of eligibility and appeal rights that render them invalid.

[10]The Department belatedly brought to the Board's attention the recently-decided case of Disabled Rights Union v. Kizer, U.S.D.C., C.D. Calif., No. CV 87-3901-WPG, August 27, 1990. However, because Kizer, like Fratone and Armstrong (see supra), misconstrues the statutory definition of eligibility contained in 42 U.S.C. э 1396d(a)(vii) and does not consider or address the unambiguous right to a state appeal hearing contained in 42 U.S.C. э 1396a(a)(3), its analysis is deemed inapt and unpersuasive.

# # #