



3. In response to that letter, the petitioner both reapplied for Medicaid based upon disability and filed an appeal of the June 19 notice.

4. The petitioner believes she is disabled under the Medicaid regulations. She was originally found eligible for Medicaid based on her receipt of ANFC since eligibility connected with that program is automatic. The petitioner has a disease of the blood for which she receives monthly treatments and medications averaging about \$150.00. She appealed the Department's decision because she was told she would get continuing benefits and she needed to pay for those treatments and for surgery which she had in July. She has cooperated in providing physicians statements to Medicaid but her new application is still pending.

ORDER

The Department's decision to terminate the petitioner's Medicaid eligibility is reversed and remanded to determine whether she meets any other categories of eligibility before a final decision terminating her benefits is made.

REASONS

When a Medicaid recipient's situation changes, the Department's regulations require a complete eligibility review prior to a decision on continued benefits:

Once granted, Medicaid coverage continues until a decision is made to end it because the person (or group) no longer passes all the eligibility tests or the recipient chooses not to continue Medicaid coverage although still eligible. Eligibility must be reviewed to take into account any changes in the facts of the recipient's situation from the facts on which the grant decision was based. . .

Eligibility reviews are carried out under the same rules as initial eligibility investigations (see Section M123 - M126).<sup>1</sup> New up-to-date forms must be filed and proofs given. Interviews are not, however, required, but may be used to clear up incomplete or inconsistent information. Collateral sources may also be used as needed.

Medicaid Manual § 131

Following this review, the regulations require that:

"A decision must be made to continue or close Medicaid coverage. . .

Medicaid is continued when a person's current situation continues to pass all necessary eligibility tests. . .

Medicaid is closed when a person's situation no longer passes any one or more of the eligibility tests. . .

Medicaid Manual § 133  
(emphasis added)

Medicaid eligibility tests have both "financial" (income and resources) and "categorical" requirements. Categorical eligibility may involve passing one of four tests:

In order to be found eligible for Medicaid, an individual must meet one of the following requirements:

(1) be found eligible for SSI/AABD financial assistance as determined by the Social Security Administration, or

(2) be found eligible for ANFC financial assistance as determined by the Department of Social Welfare, or

(3) be found eligible for Medicaid as determined by the Department of Social Welfare's application of SSI/AABD-related Medicaid rules, or

(4) be found eligible for Medicaid as determined by the Department of Social Welfare's application of ANFC-related Medicaid rules. . .

Medicaid Manual § 115  
(emphasis added)

The above regulations unequivocally require the Department upon learning of changed circumstances to thoroughly review the eligibility of a Medicaid recipient under all potential categorical criteria before terminating Medicaid coverage. There is nothing in the regulations authorizing termination of benefits solely for failure to meet the eligibility criteria of the category upon which the initial decision to grant benefits was made. These regulations are based on federal regulations (45 C.F.R. §§ 435.4, 435.930(b), and 435.916(c)(1)) which require that upon learning of a change of situation eliminating one category, that the Department must promptly determine a Medicaid recipient's eligibility under other categories before benefits are discontinued. See Crippen v. Kheder 741 F. 2d 102 (1984).

The notice of decision terminating the petitioner's Medicaid sent by the Department indicates some understanding of the above principle but is based on a woefully inadequate review process. There is no evidence here that the Department made any effort whatsoever to determine whether the petitioner might remain Medicaid eligible for some other reason such as disability. Its conclusions were based merely on the lack of a disability claim in their records. (The Department does not explain why there should be one.) If the worker had even spoken with the recipient as part of

his review, he would have learned immediately that the petitioner felt she was disabled and he could have started processing forms for a new category without interrupting her coverage.

The fact that the petitioner was encouraged to and did reapply for benefits as a disabled person does not cure the above defect because the petitioner could be facing months of hospital and doctor bills before her eligibility is redetermined. The Department's actions illegally forced the petitioner to appeal to continue her benefits, which fortunately, she did promptly. The Department's decision to terminate Medicaid benefits was premature and the petitioner's benefits should be reinstated until such time as a new decision can be made based on a thorough evaluation of her eligibility under the other categories.

FOOTNOTES

<sup>1</sup>These sections cover the preparation of a statement of need, a face-to-face interview, the provision of Social Security number and verification of information.

# # #