STATE OF VERMONT

HUMAN SERVICES BOARD

In re) Fair Hearing No. 14,905

)

Appeal of)

)

INTRODUCTION

The petitioner appeals the decision by the Department of Social Welfare not to provide coverage under Medicaid for certain medical services she obtained in the late fall and early winter of 1996/97. The issue is whether the Department is liable to pay for medical services that were provided to the petitioner under the mistaken belief by the petitioner and her providers that she was eligible for Medicaid.

FINDINGS OF FACT

Except as noted below, the facts in this matter are not in dispute. The petitioner applied for Medicaid and VHAP in October, 1996. At the time, the petitioner had no dependents and was working part time. Thus, she was categorically ineligible for Medicaid.[(1)] She was, however, found eligible for VHAP, a more limited program for low income individuals who do not qualify for Medicaid.

At that time, individuals who were eligible for either VHAP or Medicaid were issued magnetic plastic cards (like credit cards) by the Department, each program having its own card. Medicaid/VHAP recipients and providers were instructed that recipients should present their cards for the provider to electronically "swipe" to confirm eligibility before any medical service is rendered.

On or about October 9, 1996, the Department issued the petitioner a VHAP card by mail along with a notice of her eligibility for that program. The Department concedes that its records confirm that on or about October 26, 1996, it also mailed the petitioner a Medicaid card in error. The Department maintains that the Medicaid card must have been sent to the petitioner unaccompanied by any notice or explanation because there is no computer record of any Medicaid notice having been sent to the petitioner. The petitioner maintains, however, that she did receive a notice with the Medicaid card telling her that she was eligible for Medicaid and ineligible for VHAP. (Fortunately for the Board, this factual dispute need not be resolved in order for it to dispose of this matter.)

When she received the Medicaid card, believing she was eligible for Medicaid, the petitioner promptly scheduled and attended several medical appointments to address problems for which she had deferred seeking attention due to financial constraints and the fact that these services weren't covered under VHAP. The petitioner alleges, and the Department does not dispute, that she would not have scheduled these appointments if she did not believe they would be covered by Medicaid.

Apparently (and inexplicably), none of the petitioner's providers attempted to verify her Medicaid eligibility before they rendered medical services to the petitioner. Although she did not know it at the time, the petitioner does not now dispute that had her providers done so they would have been informed by the Department (electronically) that she was not eligible for Medicaid.

When the providers billed Medicaid for the services they had provided to the petitioner the Department denied them payment. When the providers notified the petitioner of this the petitioner notified the Department, at which time the Department informed the petitioner that she was ineligible for Medicaid and that her card had been issued in error.

In refusing to pay the petitioner's providers for these services the Department maintains that the providers' failure to verify the petitioner's Medicaid eligibility in advance prevents them, under their "agreements" with the Department to provide Medicaid services, from billing the petitioner for these services. Until very recently (this appeal was delayed several months for the Department to formulate its position vis-a-vis provider liability) the petitioner's providers had withheld billing her for those services pending the outcome of this appeal. Thus, the Department argues that it is not liable to the petitioner to pay her providers for the medical services in question.

ORDER

The Department's decision is affirmed. If any of the petitioner's medical providers attempts to bill the petitioner for the services in question the Department shall inform that provider of its position that this is in violation of its Medicaid agreement and that it will take appropriate action against that provider if the provider persists in billing the petitioner.

REASONS

The Department has represented to the Board that it interprets its agreement with providers of Medicaid services as prohibiting those providers from billing patients for any medical services rendered to the patient that were billed to Medicaid for which the provider did not determine in advance the patient was eligible for Medicaid coverage. If this is the case, and the petitioner cannot be held liable to her providers for these bills, it must be concluded that the petitioner does not have a continuing grievance against the Department within the meaning of 3 V.S.A. § 3091(a). It must also be concluded that the petitioner does not have standing to challenge the Department's interpretation of its Medicaid agreements with providers.[(2)]

However, these conclusions can be reached only if the Department takes responsibility for informing the petitioner's medical providers of its decision and, if necessary, enforcing its interpretation of the Medicaid provider agreement against any provider. It would then, of course, be up to the providers themselves, not the petitioner, to determine whether to pursue a grievance against the Department. The petitioner will have no liability to her providers unless and until one or more of her providers successfully appeals the Department's interpretation of the Medicaid provider agreement. At that time, the Board could consider whether the Department must then cover the petitioner under Medicaid and pay her providers for those services.

Until that time, however, the Department cannot leave the petitioner to deal with her providers over these bills. If it is the Department's position that the providers cannot under Medicaid hold the petitioner

liable for those bills, it must affirmatively take that position with any of the petitioner's providers who attempt to hold the petitioner liable for those services. With that condition and understanding, the Department's decision in this case is affirmed.

# # #

1. To be eligible for Medicaid an individual must be "related" to either ANFC (i.e., have needy dependent children) or SSI (i.e., be either elderly or disabled).

See Medicaid Manual §§ M200 and M300.

2. In deciding this matter the Board need not--and, arguably, cannot--look beyond the interpretation of the Medicaid provider agreement proffered by the Department.