

STATE OF VERMONT

HUMAN SERVICES BOARD

In re ) Fair Hearing No. 18,952  
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Appeal of )  
 )

INTRODUCTION

The petitioner appeals the decision of the Department of Prevention, Assistance, Transition, and Health Access (PATH) finding her ineligible for continuing Medicaid coverage after February 29, 2004. The issue is whether the petitioner's Medicaid benefits should have been continued when she requested a fair hearing on March 1, 2004.

FINDINGS OF FACT

1. The petitioner lives with her minor daughter. At all times herein the petitioner's daughter has been eligible for Dr. Dynasaur benefits. Prior to March 1, 2004 the petitioner received "transitional" Medicaid benefits, a time-limited program of medical coverage with income guidelines more generous than most other state-administered medical programs.

2. A Department notice regarding recently instituted program fees and copayments dated December 18, 2003 included a notice to the petitioner that her eligibility for health care

was scheduled for review on February 29, 2004. The notice further advised her that the Department would send her a "reminder letter telling you what to do if you want your coverage to continue".

3. On or shortly after January 9, 2004 the Department sent the petitioner a **Review Reminder Notice** advising her to complete and return the enclosed "review forms" by February 20, 2004 "if you wish to have your coverage continue". The notice also stated: "If a review is not completed, your health care coverage will end."

4. On or shortly after February 4, 2004 the Department sent the petitioner a **Second Reminder Notice** advising her that the Department had not yet received the review form. This notice included the following:

Without your review form, we cannot find out if you are still eligible for health-care coverage. If you do not return your review form by February 20, 2004, we cannot complete a review and health care coverage will end on February 29, 2004 for any family member who is due for review.

5. Sometime around February 20, 2004 the Department sent the petitioner a **Health Care Closure Notice**. The notice advised the petitioner that because the Department had not received her review form by February 20, 2004, her eligibility for Medicaid would end on February 29, 2004.

6. The petitioner admits that she received all the notices sent to her by the Department but did not contact the Department until February 20, 2004 (a Friday) when she called the Department's Health Access Eligibility Unit (HAEU) to ask HAEU to fax her a review form that day. However, the unit mailed the form, and the petitioner alleges that she did not receive it until February 23 (the following Monday).

7. It appears the petitioner returned the form to HAEU promptly after receiving it. On February 26 or 27, (Thursday or Friday that same week) HAEU mailed the petitioner a notice finding her ineligible for Medicaid and VHAP because of excess income. The petitioner filed her appeal in this matter on March 1, 2004 (a Monday), the first business day after she received the above notice of denial.

8. Because it had closed the petitioner's benefits on February 29, 2004 the Department did not continue the petitioner's Medicaid benefits pending the outcome of the appeal she filed on March 1, 2004. Instead, it treated the petitioner's appeal as one involving its denial of the petitioner's *application* for benefits, which it had received on or shortly after February 23, 2004.

9. A hearing was held in this matter on April 5, 2004. At that time the petitioner stated that she now does not

dispute that she was not eligible for Medicaid or VHAP as of March 1, 2004 *based on her income*. She argues, however, that had the Department faxed her the review form on February 20, when she requested it, she would have returned it that same day. She maintains that this would have enabled the Department to notify her of the closure of her benefits one or two days earlier, which in turn would have allowed her to file her appeal before the closure of her benefits on or before February 27, 2004 (a Friday). Even though the petitioner does not now dispute the *substance* of the Department's notice of February 26, she maintains that her Medicaid should have been continued pending her appeal (which she now concedes she would lose) because she *would have filed* the appeal prior to the closure date of February 29, 2004, had the Department faxed instead of mailed her the review form on February 20.

ORDER

The decision of the Department is modified. The petitioner shall be eligible for retroactive Medicaid coverage from March 1, 2004 until the date of the Board's decision in this matter.

REASONS

As noted above, the petitioner in this matter *now* has no dispute as to the Department's *latest* decision (made on or about February 26, 2004) that she is ineligible for Medicaid and VHAP as of March 1, 2004 based on her income being in excess of those programs' maximums. The sole issue on appeal is whether her Medicaid should have continued after February 29, 2004 based on the request for a fair hearing she made on March 1, 2004 of the Department' *earlier* decision to close her benefits based on her failure to return her review form by February 20.

The regulations are, indeed, clear that the petitioner is entitled to continuing benefits pending her appeal. However, this is not because the Department failed to fax a new review form to her on February 20, as the petitioner has argued. It is because the Department's closure notice was untimely. As a result, it cannot be concluded that the Department provided the petitioner with the requisite ten days of advance notice before it terminated the petitioner's benefits. Thus, the petitioner's appeal of this action, which she filed on March 1, 2004, must be considered timely to have entitled her to continuing benefits until it is decided by the Board.

W.A.M § M141 includes the following requirement:

When an eligibility review decision will end or reduce the amount of Medicaid coverage an individual has been receiving, the notice of decision must be mailed at least ten (10) days before the closure or change will take effect. . .

In this case, the Department couldn't possibly have made a legitimate decision to close the petitioner's Medicaid until after the end of the business day on February 20, 2004, the date it had expressly given the petitioner as the deadline to return her form. The Department cannot avoid the 10-day notice requirement simply by "warning" a recipient in advance that her benefits will close within *less than 10 days* if she fails to take some action required of her by a certain date in the future. Certainly, no such exception appears in the regulations.

In this case, the "reminder notices" sent to the petitioner on or about January 9 and February 4 were just that--reminders. Even though one of them mentioned a potential closure date of February 29, this was clearly less than ten days following the deadline imposed by that same notice. Neither "reminder notice" can be construed as a requisite "notice of decision" as contemplated by § M140, *supra*, because a "decision on (the) review of eligibility" for the petitioner clearly had yet been made. Moreover (at least

based on the copies furnished to the hearing officer by the Department in this fair hearing), neither reminder notice contained "an explanation of the petitioner's right to appeal" or "an explanation of the circumstances under which Medicaid is continued if a hearing is requested", as also required by § M140. The only correspondence the Department sent the petitioner that was labeled a "closure notice", and which otherwise met the requirements of § M140, was the one sent on or after February 20, which, as discussed above, was clearly untimely.

Thus, as a matter of law and fundamental fairness it must be concluded that the earliest effective date the Department could have closed the petitioner's Medicaid for any reason was March 1, 2004, ten days after February 20, which was the earliest the Department can claim to have acted following the petitioner's failure to comply with her review deadline of that same date.

The regulations are also clear that when an individual requests a fair hearing "before the effective date of the adverse action" benefits are to continue "until the appeal is

decided". W.A.M. § M143.<sup>1</sup> Nothing in the regulations, or in the Board's experience, suggests that the right to continuing benefits pending appeal is in any way contingent upon the ultimate merits of that appeal, or upon any other action that is subsequently taken in an individual's case. In this case, even though the petitioner *now* concedes that the Department was correct in *later* finding her ineligible to continue receiving Medicaid *based on her income*, there is no question that she was fully entitled under the regulations to appeal the decision to close her benefits *due to her failure to timely return her review form*.<sup>2</sup> Moreover, considering the fact that she clearly did so within ten days of the earliest date the Department could have made that decision, she was clearly entitled under the above regulations to continue to receive Medicaid benefits until the Board decides that appeal.

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<sup>1</sup> The only condition in a case such as this is that the recipient "continue to pay any required program fees throughout the appeal process". However, this is a moot point because the Department did not continue the petitioner's benefits pending appeal. Under this provision, however, the petitioner may well be liable for program fees regarding any retroactive Medicaid coverage that is awarded to her pursuant to this appeal.

<sup>2</sup> Had the petitioner returned her review form prior to February 20, it is clear that the Department's decision that she was no longer eligible for Medicaid based on income would have been considered a "closure" of her benefits, subject to the ten-day notice provisions and the right to continuing benefits if timely appealed. There is no indication that the petitioner would not have filed an appeal in this matter even if from the outset the sole question regarding her "closure" was whether she was over-income. Thus, it cannot be found that the petitioner has gained anything in this matter from her delay in returning her review form.

Based on the above, it must be concluded that as "appropriate relief" the Department must grant the petitioner retroactive Medicaid coverage for any covered medical expenses she has incurred from March 1, 2004 until the date of this decision. 3 V.S.A. 3091(d), Fair Hearing Rule 17.

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