

\$81 per month for prescription coverage due to acid reflux disease for which she regularly takes Prilosec and Prevacid.

3. On September 15, 2004, DCF sent the petitioner a notice telling her that her transitional Medicaid would end on September 30, 2004 because it had run for three years. She was told that her current income put her over the limit for regular Medicaid and that she would have to "spend-down" \$389.40 in order to become eligible for Medicaid again. The notice advised the petitioner that she was being rolled over to the VHAP program and that her monthly premium for that insurance would be \$35.00. The petitioner's son was moved to the Dr. Dynasaur program and was not required to pay a premium. The petitioner says she did not receive this notice.

4. Subsequent to this notice, DCF realized that the petitioner had health insurance through her employer and determined she was granted VHAP benefits in error. The petitioner was notified on October 19, 2004 that her VHAP insurance would end on October 31, 2004 because she had other insurance.

5. Because the petitioner did not receive the first notice, she was confused about the notice closing her VHAP benefits which she was not aware that she had. The

petitioner continues to ask for help with prescription drug coverage.

ORDER

The decision of DCF is affirmed.

REASONS

Under regulations adopted by the Department, "Medicaid groups who no longer meet the ANFC-related eligibility criteria because a parent . . . has new or increased earnings continue to be eligible for transitional Medicaid (TM) for up to 36 months, beginning the month immediately following the months in which the group becomes ineligible" provided that net income after the sixth month does not exceed 185 percent of income for the family size. M302.21. The 185 percent level for a two-person household was \$1,926 per month during the period at issue. P-2420B. The petitioner's net income was well below that figure so she qualified financially for the program. However, her thirty-six month maximum period ran out at the end of October of 2004. DCF was correct to remove her from that program based on the time factor and appears to have duly notified her of that fact although the petitioner did not receive the notice.

When the petitioner no longer met the TM criteria, she was assessed to see if she met the regular Medicaid criteria. The two-person maximum for that program is \$783 per month. P-2420B. The petitioner's income was correctly found to be in excess of that amount but a "spend-down" figure was provided to the petitioner to allow her to return to Medicaid if her medical bills exceeded her ability to pay. The petitioner does not dispute the calculation of that amount. If the petitioner incurs medical bills (including insurance premiums) over \$389.40 in a six-month period, Medicaid will pick up the excess. The petitioner is encouraged to keep careful track of any medically related bills, including transportation to medical appointments, and present them to DCF when she comes near her spend-down amount.

DCF's regulations provide coverage under VHAP only to those persons who are "uninsured or underinsured" and defines those persons as individuals who "do not qualify for Medicare and have no other insurance that includes both hospital and physician services." VHAP 4001.2. The petitioner does have other insurance that covers hospital and physician services so she does not meet the above definition and DCF correctly terminated her from that program after it discovered her other insurance. DCF does have other programs that cover

prescription costs for persons who have insurance without prescription coverage but those programs eliminate persons who are not disabled or elderly. See VHAP 3200 and 3300. As the petitioner appears to have some prescription coverage under her current insurance and is neither elderly nor disabled (the equivalent of an SSI recipient), she is not eligible for any prescription program other than Medicaid once she meets her spend-down. As the decision of DCF with regard to the petitioner's eligibility is consistent with its regulations, the Board is bound to uphold the result. 3 V.S.A. § 3091(d), Fair Hearing Rule 17.

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