



whether the petitioner should pay the bills with her savings. The intake worker advised the petitioner to wait to make payments until she learned whether she met the disability criteria for Medicaid eligibility. She feared that the petitioner might not be reimbursed for bills she paid herself. The petitioner and the worker had no further conversations on this matter. The worker contended later that the information on paying the bills was not really advice and that she had no duty to give advice to her clients.

The worker never advised petitioner that she would have to spend down excess resources on medical expenses in order to preserve her eligibility for Medicaid coverage during the month of application, and the three months prior to application. Similarly, the worker never advised petitioner that, although she could become financially eligible by spending down excess resources for any purpose, in order to preserve coverage for the three month period prior to satisfying any spend-down requirement, she would have to demonstrate that the spend-down had been met through payment of medical expenses.

7. Sometime in late July, before a decision had been made on her application, the petitioner spoke with an advocate from the Area Agency on Aging about her Medicaid eligibility and was told that she needed to spend all but \$2,000.00 of her savings to be eligible for Medicaid.

8. Between June 26 and August 8, 1990, the petitioner spent some \$2,550.00 of her savings account in order to become Medicaid eligible. She spent \$600.00 on physician's bills, \$125.76 on prescriptions and \$315.00 on maintenance.

In late July, 1990 the petitioner purchased a car for \$750.00 in cash. In order for the car to run properly, she also purchased ball joints for \$80.00 and a new tire for \$30.00. Her car insurance cost \$232.00. The rest of the money (about \$500.00) was spent on personal, non-medical expenses.

9. Although she does not drive, the petitioner purchased the car so that her daughter and her male friend could drive her back and forth to Hanover, New Hampshire for chemotherapy at Dartmouth-Hitchcock Medical Center. At the time, she was not aware that there might be a van taking patients to Hanover for treatments, nor did she investigate the possibility of such a van. Neither was she aware of Medicaid funded transportation possibilities, nor was she even certain, when she bought the car, that she would be found eligible for Medicaid. The worker testified that, at one point, she was aware of a van taking patients to Hanover for chemotherapy, though she was not certain at the date of the hearing whether the van was still in operation.

10. On August 8, 1990, the petitioner filed a second Medicaid application with the assistance of an advocate from the Area Agency of Aging. By that time, the petitioner had spent her resources down to \$1,617.00. When she filed the

second application, the petitioner had not received a decision concerning the first application.

11. In September, the petitioner was found by the Department to be eligible for Medicaid based on her second application as of August 1, 1990. However, because the Department determined that she had excess resources of \$1,140.53<sup>1</sup> which had not been spent for medical expenses during the three month period of May, June, and July 1990, the petitioner was denied coverage for that time period. This left her with \$2,411.28 in unpaid surgical bills (her hospital costs were paid by the Hill-Burton Fund).

12. As it turned out, the petitioner did not need to go to Hanover for chemotherapy treatments because she was able to get them in St. Johnsbury. The car she purchased has been loaned to her daughter.

13. If the petitioner had been told on July 9 that she needed to pay her medical expenses to be eligible for May, June and July, she would have paid those expenses immediately instead of buying the car or making the other expenditures.

ORDER

The Department's decision is reversed and the petitioner is found eligible for June and the three preceding months.

REASONS

Eligibility for the Medicaid program requires passing a resource test which for one person is set at a \$2,000.00

maximum. M ə 340, P ə 2420(c). If a person has more than the resource maximum, she may still be eligible for Medicaid if her "excess" resources, the amount over and above the maximum limit, is "spent down" to the maximum level:

If an excess resource amount remains after the above exclusions have been applied, the applicant has not passed the resource test. An applicant may become eligible for Medicaid by spending or giving away excess resources. Medicaid may be granted for the month of application if the resource test is passed at any point in the month and all other eligibility criteria are met. Individuals who spend down resources according to the policy on Excess Resources in the chapter on Medical Expenses Spend-Down may be granted up to three months of retroactive Medicaid Coverage if eligible for retroactive coverage.

M ə 235 (emphasis added)

A person who passes all eligibility tests, except that his or her Medicaid group's countable resources exceed the applicable Resource Maximum, may qualify for Medicaid coverage by spending down the excess amount. The resources "spend-down" test is not, however, passed until the person or group shows proof that the excess amount is no longer held as a resource and has actually been spent.

If any of the following actions is taken, eligibility may begin on the earliest date the Medicaid group passed all other eligibility tests--i.e., up to three months prior to the month of application . . .

3. The group may spend money on covered or non-covered medical expenses.<sup>2</sup>

Any other action(s) which reduces countable resources may be taken if the Medicaid group lives in the community. As long as resources are reduced to the applicable resource maximum and all other tests are passed, Medicaid may be granted effective the first of the month the action is taken, but not for any previous months . . .

M ə 401 (emphasis added)

In short, this regulation provides for the initiation

of Medicaid benefits in any month during which the excess resource (in this case the amount over \$2,000.00) is spent, regardless of how it is spent. However, if retroactive benefits are sought, i.e., benefits for the three months before the date of application, the excess resource must be spent on allowable medical expenses. Deductible medical expenses include all services which would be covered by Medicaid and services not covered by Medicaid if they are medically necessary. See generally M 3 430 et seq. The regulations specifically include the reasonable cost of transportation to secure medical services. M 3 432

In this case, the petitioner reported excess resources in the amount of \$2,167.64 (\$4,167.64 - \$2,000.00) at the time she applied for Medicaid on June 26, 1990. Although she had incurred medical expenses of over \$2,411.28 at the time she applied, she, in fact, did not pay those expenses in June or in any month afterward. Given these facts, the petitioner may not be found eligible for June or the three months preceding under the regulations cited above.

Sometime between June 26, and August 8, the petitioner spent about \$2,500.00 which put her under the resource maximum for August, regardless of how the money was spent. In order to be retroactively eligible under the August application, i.e., for the months of May, June and July, the petitioner was required under the regulations to present proof that she spent at least \$2,167.64 of that amount on Medical (and/or maintenance) expenses.

The evidence shows that the Department found that the petitioner spent \$1,027.11 during the months of July and August on allowable medical and other expenses for purposes of her spend down.<sup>3</sup> That figure is \$1,140.53 short of the spend down needed for eligibility. However, the petitioner argues that the expense of her car, which totaled \$1,092.00 should have been included as a spend-down deduction since it was purchased to provide transportation to medical services.

Even if the car were included as a medical cost, the petitioner would still have been \$48.53 short of the needed spend down amount. However, even if the \$48.53 gap could be closed by further proof of medical expenditures in the period at issue, there is no basis for including the car as a cost necessary for transporting the petitioner to medical services. That conclusion is based on the simple fact that the car was, in fact, not needed and never used to transport the petitioner to medical services. There was no evidence that the car would be so used in the future. In fact, the evidence now shows that the car is not used by the petitioner at all for any reason but is in her daughter's possession. Given these facts, it is not necessary to analyze whether a car might be includible as a medical transportation expense as this car clearly is not.

It must be concluded that the Department is correct in its application of the regulations with regard to the petitioner's dates of eligibility. The petitioner asserts, however, that the Department should be estopped from

applying its regulations to find the petitioner ineligible because the Department's actions unjustly caused the petitioner to take or not to actions which led to her ineligibility for Medicaid under her first application.

The Board, relying on Burlington Fire Fighters Association, et al., v. City of Burlington, 149 Vt 293, (1988), has held that estoppel against the Department is a rarely used remedy which requires that the petitioner prove "the existence of the traditional four elements of estoppel and that the injustice involved is so great that it outweighs the public interest in seeing the government carry out its usual obligations" Fair Hearing No. 9273. The elements of estoppel, as set forth in Fisher v. Poole, 142 Vt 162, 168, and adopted by the Board are as follows:

1. The party to be estopped must know the facts;
2. The party being estopped must intend that his or her conduct shall be acted upon or the acts must be such that the party asserting the estoppel has a right to believe it is so intended;
3. The latter must be ignorant of the true facts; and
4. The party asserting the estoppel must rely on the conduct of the party to be estopped to his detriment.

It must be concluded, for reasons which will follow, that the facts in this matter meet the four traditional elements for estoppel.

First, the Department's representative knew the pertinent facts in this matter, namely that the petitioner had reported over \$4,000.00 in countable resources on her application dated June 26, 1990 and that she had incurred

over \$2,000.00 in medical expenses. The Department's representative also knew based on her conversation with the petitioner on July 9, 1990, that the petitioner was anxious to pay her bills and was seeking information on whether she should do that while her Medicaid application was pending.

Second, although the Department's representative contended at the hearing that she had no duty to advise the petitioner on the payment of her medical bills and did not do so, that assertion is both legally and factually incorrect. The Vermont Supreme Court has held with regard to ANFC benefits "that the department has an affirmative duty to advise applicants specifically of their rights. . ." Lavigne v. DSW, 139 Vt 114, 118 (1980). There is no reason to suppose that the level of obligation is any less in the Medicaid program. The Department had a clear duty to advise the petitioner that her current and retroactive eligibility for Medicaid depended upon her payment of her medical bills. The petitioner was not so advised. Instead, she was clearly advised not to pay her medical bills by the Department's representative, who, though genuinely concerned about reimbursements, thought she had given the petitioner some helpful advice, but nevertheless failed to adequately apprise the petitioner of her rights.

There is every reason to believe that the Department's representative intended that the petitioner should act upon that erroneous information. At the very least, it must be found that the petitioner had a right to believe that the

information given to her regarding payment of her bills was to guide her in her actions. After all, she got this information in the course of a phone interview on her Medicaid application which was initiated by the Department.

There was no reason for her to believe that this unequivocal advice was casual or potentially incorrect.

Third, the petitioner never learned until the Department's decision was made in September of 1990, that she was required to pay her bills in order to be eligible for March, April, May, June, and July of 1990. She did learn from a non-Department source in late July or early August that she could become eligible under a new application if she spent down her money, but that information did not help her to understand how she could become eligible for the time she was in the hospital.

Fourth, the petitioner relying on the information given to her by the Department took steps or failed to take steps which resulted in a detriment to her, namely the loss of Medicaid eligibility for the months of March through July of 1990, during a period when she incurred over two thousand dollars worth of medical bills. If the Department had advised her to spend her excess resources on her medical bills, the petitioner would have paid them at once and protected her eligibility. With the proper advice, she would not have failed to pay her bills and would not have had the opportunity to subsequently spend down her money on non-medical items based on further incorrect advice from a

lay advocate for the elderly.

The petitioner has met her burden of showing that the traditional elements of estoppel are met. She has also put forward facts which show that the injustice to her is so great that the Department should not be allowed to enforce its Medicaid eligibility regulations against her. Because of the Department's actions, the petitioner is left with over \$2,000.00 of unpaid medical bills which she cannot afford to pay and may never be able to pay because of her inability to work. There is a risk that she will face legal action to collect those amounts which could include a lien on her home. The Department, on the other hand, is merely prevented from declaring the petitioner ineligible for benefits for months when she should have been found eligible if she had been told to and did spend down her money. The petitioner has already spent about \$725.76 of that money on medical expenses leaving about \$1,441.88 on the amount she would have had to spend down. The petitioner does not have the excess resources to make that spend down now due to misinformation from the Department. The Department is in a much better position to absorb the \$1,441.88 extra payment because of its mistake than the petitioner is to absorb over \$2,000.00 in unpaid medical bills.

It must be concluded, that justice dictates that the Department find the petitioner eligible for Medicaid for the months of March, April and May retroactively, and June and July prospectively, based on her application in June based

on the erroneous information it gave her.

FOOTNOTES

<sup>1</sup>It can be concluded from this determination that the Department allowed her \$1,027.11 towards the spend-down for July and August.

<sup>2</sup>Paragraphs 1 and 2 involve applied income tests which are not at issue here.

<sup>3</sup>This figure is taken from the Medicaid notice which stated that the petitioner had \$1,140.53 in excess resources for May, June and July. The petitioner in a memorandum filed after hearing alleges \$1,300.00 worth of includible expenses but did not document or point out where her figures differ from the Department's. It appears that she may have been using figures of expenses paid in May or June which most likely were already deducted from the patient's resources when she applied. In the absence of any documentation to the contrary, the Department's figures are being used.

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