STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT 06105-3725

[redacted] **2017**
Signature Confirmation

Client ID # [redacted]
Request # 774357

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2016, the Department of Social Services (the "Department") sent [redacted], (the "Appellant") a Notice of Action ("NOA") denying his application for long-term care medical assistance under the Medicaid program.

On [redacted] 2014, the Appellant requested an administrative hearing to contest the Department's decision to deny the Appellant's application for Medicaid.

On [redacted] 2016, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted], 2016.

The administrative hearing was rescheduled several times at the Appellant's request.

On [redacted], 2016, OLCRAH issued a notice scheduling the administrative hearing for [redacted] 2016.

On [redacted], 2016, in accordance with sections 17b-60, 17b-61 and 4-176e to 4-189, inclusive, of the Connecticut General Statutes, OLCRAH held an administrative hearing.

The following individuals were present at the hearing:

[redacted] Appellant's Attorney
Amy Kreidel, Department's Representative
Sybil Hardy, Hearing Officer

On [redacted] 2016, the undersigned reopened the hearing record until [redacted], 2016, to enter into the hearing record *Williford v. North Carolina Department of Health & Human Services,* 792 S.E.2d 843 (N.C. Ct. App. 2016), and to allow the parties to respond to the decision's inclusion in the record.

On [redacted] 2016, the hearing record closed.

STATEMENT OF THE ISSUE

The issue is whether the Department correctly denied the Appellant's long-term care Medicaid application due to excess assets.

FINDINGS OF FACT

1. On [redacted], 1989, the Appellant suffered a work-related fall, causing various injuries including fractures to the lumbar spine, heel (calcaneus) and foot (metatarsal) with accompanying brachial plexus palsy, retinal detachment, cervicothoracic strain, radiculopathy of the upper and lower extremities, PTSD and major depressive disorder. (Exhibit G: [redacted] Medicare Set Aside Custodial Agreement, [redacted] 2005)

2. On [redacted], 2005, a Workers Compensation Medicare Set Aside ("WCMSA") custodial agreement was made by and between (1) the Appellant, (2) the insurance carrier for the Appellant's employer, Liberty Mutual Insurance Company ("Liberty Mutual"), and (3) Medi-Bill, Inc. ("Medi-Bill"), the company selected to act as custodian of the WCMSA account.

3. The custodial agreement required Liberty Mutual to establish a custodial fund for the Appellant's benefit, and required Medi-Bill to administer and make distributions from the custodial fund for the Appellant's benefit. (Exhibit G page 1)

4. Regarding distributions from the custodial fund, the custodial agreement provides as follows: "This Custodial Fund, including the income earned on it, is to be expended by [the] Custodian[1] only for reasonable medical expenses of the Beneficiary, not to include outpatient prescription drug, attendant care costs, and all other medical expenses not reimbursable by Medicare. . . . [T]his Custodial Fund will make payments on behalf of [the] Beneficiary[2] only on those medical expenses that are medically necessary, as determined by the Custodian, for the Beneficiary's hospital care, skilled and intermediate care, skilled rehabilitation, home health care and hospice care related to and associated with the medical needs of the Beneficiary as the result of the injuries sustained on or about [redacted]/1989, and any and all injuries or medical conditions reasonably resulting therefrom. This Custodial Fund will pay for

[1] The custodial agreement refers to Medi-Bill as "the Custodian."
[2] The custodial agreement refers to the Appellant as "the Beneficiary."

medical benefits that would ordinarily be reimburseable by Medicare, and are related to the work injury of the Beneficiary." (Exhibit G page 2)

5. On [redacted], 2015, the Appellant was admitted to a skilled nursing facility, Meridian Manor (the 'nursing facility"), in [redacted], Connecticut. (Hearing Record, Exhibit B: Eligibility Management System ["EMS"] Narrative Screen, Exhibit K: ASCEND Admission)

6. The Appellant was admitted to the nursing facility with a diagnosis of dementia, atrial fibrillation, HTN, blindness in one eye, low vision in the other eye, atherosclerotic heart disorder, traumatic brain injury, intracranial injury, chronic edema, muscle weakness and chronic back pain. (Exhibit F: Email Correspondence between Attorney [redacted] and Liberty Life Assurance, Exhibit L: ASCEND Notes)

7. For the period of [redacted] 2015 through [redacted] 2016, the Appellant paid all his nursing facility expenses. (Hearing Record)

8. On [redacted] 2016, the Department received an application on behalf of the Appellant for long-term care assistance under the Medicaid program. (Hearing Record, Exhibit C: Long-Term Care Application, Exhibit H: Notice of Action, [redacted]/16)

9. On [redacted] 2016, the Appellant had the following assets:

Assets	Balance	Name on Account
TD Bank xxxx[redacted]	$499.00	Appellant
Resident Account xxxx[redacted]	$942.17	Appellant
WCMSA	$77,093.00	Appellant

(Exhibit C, Exhibit G: Medicare Set Aside Account, Exhibit M: TD Bank Statement, Exhibit N: Patient Account Statement, [redacted]/13)

10. On [redacted] 2016, the Appellant's attorney sent a formal demand to Medi-Bill requesting the release of funds from the Appellant's WCMSA account to pay for his medical expenses, including the cost of care at the nursing facility. (Exhibit 5: Letter dated [redacted] 2016 to Medi-Bill, page 1)

11. On [redacted], 2016, Medi-Bill responded to the Appellant's attorney explaining that there was no provision within the contract to release the funds from the WCMSA account. (Exhibit 5: Letter dated [redacted] 2016 from Medi-Bill, page 1)

12. Medi-Bill recommended that the Appellant's attorney contact Liberty Mutual to gain its approval to terminate the WCMSA custodial agreement. (Exhibit 5: Letter dated [redacted], 2016 from Medi-Bill, page 1-2)

13. On [redacted], 2016, the Department sent the Appellant a Notice denying his application for long-term care medical assistance because the value of his assets exceeded the program asset limit. (Exhibit H: Notice of Denial, [redacted]/16)

14. On [redacted], 2016, the Appellant's attorney contacted Liberty Mutual to request that it terminate the WCMSA custodial agreement and direct all available funds and future annuity payments to the cost of the Appellant's long-term care. (Exhibit 5: Letter dated [redacted] 2016 to Liberty Mutual, page 1)

15. On [redacted] 2016, legal counsel for the Department submitted a memorandum that concludes that the Appellant's WCMSA account is a countable asset for purposes of Medicaid. (Exhibit 2: Prehearing Memorandum from Attorney Dan Butler)

16. On [redacted] 2016, the law firm representing Liberty Mutual responded to the Appellant's attorney's [redacted], 2016 letter, indicating that Liberty Mutual could not direct the funds in the Appellant's WCMSA account to cover the cost of the Appellant's long-term care unless it was authorized to do so by CMS. The law firm recommended that Appellant's attorney contact CMS. (Exhibit 5: Law Offices of [redacted], letter dated [redacted] 2016. Page 1)

17. Although not contained in the record, Appellant's attorney apparently did contact CMS because the record contains an [redacted], 2016, letter from CMS to Appellant's attorney explaining that the funds in the Appellant's WCMSA "are specifically dedicated to cover future expenses that . . . CMS . . . might otherwise pay inappropriately as they are related to a workers' compensation injury." (Exhibit 5: CMS letter dated [redacted], 2016, Page 1) The letter explained that "[t]he only point at which a beneficiary may access the funds for services other than Medicare-approved expenses related to the [workers' compensation] settlement are for administrative fees for the WCMSA or release to the beneficiary's estate once the beneficiary has expired." (Id. at Page 2)

18. On [redacted] 2016, the undersigned reopened the hearing record until [redacted], 2016, to enter into the hearing record *Williford v. North Carolina Department of Health & Human Services,* 792 S.E.2d 843 (N.C. Ct. App. 2016), and to allow the parties to respond to the decision's inclusion in the record. (Hearing Officer Exhibit 1: Letter Regarding Reopening the Administrative Hearing Record, [redacted]/16)

CONCLUSIONS OF LAW

1. Section 17b-260 of the Connecticut General Statutes authorizes the Commissioner of the Department of Social Services to administer the Medicaid program.

2. Uniform Policy Manual ("UPM") § 4005.05 (B) (1) provides that the Department counts the assistance unit's equity in an asset toward the asset limit if the asset

is not excluded by state or federal law and is either available or deemed available to the assistance unit.

3. Section 17b-261(c) of the Connecticut General Statutes provides that, "[f]or the purposes of determining eligibility for the Medicaid program, an available asset is one that is actually available to the applicant or one that the applicant has the legal right, authority or power to obtain or to have applied for the applicant's general or medical support."

4. UPM § 4005.05 (B) (2) provides that, for Medicaid, the Department considers an asset available when actually available to the individual or when the individual has the legal right, authority or power to obtain the asset, or to have it applied for, his or her general or medical support.

5. UPM § 4005.05 (D) provides that an assistance unit is not eligible for benefits under a particular program if the unit's equity in counted assets exceeds the asset limit for the particular program.

6. Although there appears to be no binding judicial authority in Connecticut addressing whether a WCMSA account should be treated as an available asset, the undersigned finds the reasoning of the North Carolina Court of Appeals' decision in *Williford* to be compelling.

7. In *Williford,* the issue before the appellate court was whether North Carolina's state Medicaid agency properly counted as an available asset a WCMSA account containing in excess of $46,000 when it discontinued the account beneficiary's eligibility for Medicaid. *Williford*, 792 S.E.2d at 846.

8. The beneficiary in *Williford* self-administered her WCMSA account, which was created to settle a dispute about the beneficiary's future medical expenses resulting from a workplace injury. *Id.* at 845, 850-51. Although the beneficiary administered the account and therefore had access to the funds held in it, the appellate court concluded that, pursuant to the terms of the settlement agreement creating the WCMSA account and applicable federal law controlling the creation and use of WCMSA accounts, the beneficiary was legally authorized to use the funds only for Medicare-covered expenses that were related to the workplace injury. *Id.* at 848. Indeed, as the appellate court explained, the purpose of these accounts "is to allocate a portion of a workers' compensation award to pay potential future medical expenses resulting from the work-related injury so that Medicare does not have to pay." *Id.* at 849 (quoting *Aranki v. Burwell*, 151 F.Supp.3d 1038, 1040 (D. Ariz. 2015)).

9. Noting that "in North Carolina eligibility for Medicaid is determined utilizing the federal standard for determining eligibility for Supplemental Security Income," (SSI) the appellate court in *Williford* observed that federal SSI regulations define a resource as "'cash or other liquid assets . . . that an individual . . . owns and

could convert to cash to be used for his or her support and maintenance,'" and explain that "[i]f the individual has the right, authority or power to liquidate the property . . . it is considered a resource. . . ." *Id.* at 847 (quoting 20 C.F.R. § 416.1201(a)(1)).

10. The appellate court in *Williford* also reviewed certain provisions of the Social Security Administration's Program Operations Manual System, including one section explaining that damages awarded for the sole purpose of paying medical expenses related to an accident should not be treated as an available resource, even if the recipient owns the funds and has direct access to them. *Id.* at 848.

11. Based on this authority, the appellate court in *Williford* concluded that an asset should be counted for purposes of determining Medicaid eligibility only if it is "*legally* available to the applicant *without legal restriction* on the applicant's authority to use the resource for support and maintenance." *Id.* (emphasis in original). Because, as mentioned above, the settlement agreement creating the WCMSA account restricted the beneficiary's legal use of the account to payment of Medicare-covered expenses associated with the beneficiary's workplace injury, the appellate court concluded that the WCMSA account was not an available asset. *Id.* at 851.

12. As in *Williford*, the WCMSA custodial agreement in the present case provides that the custodial fund may be used only to pay for Medicare-covered expenses stemming from the workplace injuries the Appellant suffered on [redacted] 1989. *See* Finding of Fact #4.

13. Furthermore, the definition of "available asset" used in Connecticut pursuant to General Statute section 17b-261(c) is strikingly similar to the SSI definition of "resource," as interpreted by the appellate court in *Williford*, in that they both speak to an individual's *legal* right to use the asset for his or her support.

14. If anything, the case for treating the WCMSA account as an unavailable asset in the present case is even stronger than in *Williford* because, unlike in *Williford*, the Appellant does not control his account, since it is administered by a third-party custodian (Medi-Bill). Furthermore, the record indicates that the Appellant's attorney did pursue release of the funds in the WCMSA account for the purpose of paying medical expenses that are not otherwise payable under the terms of the WCMSA custodial agreement, but was instructed by Medi-Bill, Liberty Mutual, and CMS that this was not possible. *See* Findings of Fact ## 10-12, 14, 16-17.

15. Based on the foregoing, the undersigned concludes that the Department incorrectly determined that the Appellant's WCMSA account is an available asset because the Appellant does not have the legal right, authority or power to obtain the funds in such account, or to have such funds applied for his general or

medical support. The funds in the WCMSA account are only available for worker's compensation related medical expenses that are payable under Medicare.

16. UPM § 4005.10 (A) (2) (a) provides that the asset limit for Medicaid for a needs group of one is $1,600.

17. UPM § 4005.15 provides that at the time of application, the assistance unit is ineligible for assistance until the first day it reduces its equity in counted assets to within the particular program asset limit

18. The Appellant's assets are less than the Medicaid asset limit of $1,600.00 when the WCMSA account is not counted.

19. The Department therefore incorrectly determined that the Appellant's assets exceeded the $1,600.00 asset limit.

20. The Department incorrectly determined that the Appellant was ineligible for Medicaid due to excess assets.

21. The Department incorrectly denied the Appellant's long-term Care Application because it incorrectly determined that the Appellant's WCMSA account was an available asset and that the Appellant's assets exceeded the program asset limit.

DECISION

The Appellant's appeal is **GRANTED**.

ORDER

1. The Department is ordered to consider the Appellant's WCMSA an unavailable asset for Medicaid.

2. The Department will grant the Appellant's Medicaid long-term care services application provided all other eligibility requirements have been established.

3. Proof of compliance with this order is due by [redacted] 2017.

Sybil Hardy

Sybil Hardy
Hearing Officer

Pc: Peter Bucknall, Operations Manager; DSS R.O. # 60; Waterbury
Karen Main, Operations Manager, DSS R.O. # 60, Waterbury
Amy Kreidel, Fair Hearings Liaison, DSS R.O. # 60, Waterbury
Daniel T. Butler, Principal Attorney, DSS, Central Office
[redacted], Attorney At Law

RIGHT TO REQUEST RECONSIDERATION

The appellant has the right to file a written reconsideration request within **15** days of the mailing date of the decision on the grounds there was an error of fact or law, new evidence has been discovered or other good cause exists. If the request for reconsideration is granted, the appellant will be notified within 25 days of the request date. No response within 25 days means that the request for reconsideration has been denied. The right to request a reconsideration is based on §4-181a (a) of the Connecticut General Statutes.

Reconsideration requests should include specific grounds for the request: for example, indicate what error of fact or law, what new evidence, or what other good cause exists.

Reconsideration requests should be sent to: Department of Social Services, Director, Office of Administrative Hearings and Appeals, 55 Farmington Avenue Hartford, CT 06105.

RIGHT TO APPEAL

The appellant has the right to appeal this decision to Superior Court within 45 days of the mailing of this decision, or 45 days after the agency denies a petition for reconsideration of this decision, provided that the petition for reconsideration was filed timely with the Department. The right to appeal is based on §4-183 of the Connecticut General Statutes. To appeal, a petition must be filed at Superior Court. A copy of the petition must be served upon the Office of the Attorney General, 55 Elm Street, Hartford, CT 06106 or the Commissioner of the Department of Social Services, 55 Farmington Avenue Hartford, CT 06105. A copy of the petition must also be served on all parties to the hearing.

The 45 day appeal period may be extended in certain instances if there is good cause. The extension request must be filed with the Commissioner of the Department of Social Services in writing no later than 90 days from the mailing of the decision. Good cause circumstances are evaluated by the Commissioner or the Commissioner's designee in accordance with §17b-61 of the Connecticut General Statutes. The Agency's decision to grant an extension is final and is not subject to review or appeal.

The appeal should be filed with the clerk of the Superior Court in the Judicial District of New Britain or the Judicial District in which the appellant resides.