UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

Superior Court of Connecticut,

JUDICIAL DISTRICT OF NEW BRITAIN.

ADMINISTRATIVE APPEALS.

ANTOINETTA ROMANELLI EXECUTRIX OF THE ESTATE OF ANTONIO ROMANELLI

v.

DEPARTMENT OF SOCIAL SERVICES

DOCKET NO. HHB-CV-21-6066045

MAY 19, 2022

MEMORANDUM OF DECISION

John L. Cordani, Judge

INTRODUCTION:

\*1 This matter is an administrative appeal of a March 31, 2021 final decision of the Department of Social Services (DSS) denying long term care Medicaid benefits for Antonio Romanelli (the “Final Decision”). Antoinetta Romanelli, as executrix of the estate of Antonio Romanelli (“plaintiff”), has brought this administrative appeal challenging the Final Decision.

FACTS AND PROCEDURAL HISTORY:

The following facts are relevant to the resolution of this appeal and are undisputed. At all times relevant to this appeal Antonio Romanelli (“applicant”) and Antoinetta Romanelli (“applicant spouse”) were married. On October 15, 2001, the applicant and applicant spouse established a Declaration of Trust with the applicant and applicant spouse as grantors and beneficiaries thereof (the “Trust”). The Trust contained two pieces of real estate, one located at 50 Biscayne Boulevard in Old Lyme, and the other located at 30 Woodmere Road in Newington. The trustees were to manage the Trust and use the assets of the Trust for the benefit of the grantors. See the Declaration of Trust, section one. In section eleven of the Trust, the grantors retained the following rights during their joint lifetimes: “(a) The right to withdraw all or any part of the trust property and to revoke this agreement entirely and the trust hereby created.” The foregoing right could be exercised only: “(a) If both grantors are alive and competent, severally, only with respect to each grantor's separate share,” and “(c) In the event of the incapacity of one or both of the grantors, this trust may not be revoked by any legal or personal representative of an incapable grantor.” On November 10, 2012, the applicant and the applicant spouse also executed a living trust, but that trust was never funded, contained no assets, and is not relevant to this appeal.

On September 19, 2019, the applicant was admitted to a long term care facility named Bel Air Manor. At all times relevant to this appeal, the applicant spouse remained living in the community. On December 3, 2019, the applicant filed an application for long term care Medicaidbenefits with DSS.1 On August 13, 2020, the applicant passed away while continuing to reside in the long-term care facility.

On September 23, 2020, DSS sent a notice to the plaintiff indicating that DSS determined that the total countable assets owned by the applicant and applicant spouse as a couple were $440,419.80, that the community spouse protected amount was $126,420.00, and that Medicaid benefits could not begin until assets were reduced to $128,0202. The foregoing asset determinations included the value of real estate in the Trust, namely the 50 Biscayne Boulevard property in Old Lyme. In view of the foregoing, and because the applicant's assets exceeded the eligibility amount for Medicaid benefits, on October 14, 2020, DSS sent a notice to the plaintiff denying the applicant's application for Medicaid benefits for the period from December 2019 through September 2020.

\*2 The plaintiff requested an administrative hearing to challenge the DSS denial of Medicaid benefits. A hearing was held on February 10, 2021. The hearing focused primarily on whether or not the assets in the Trust should be included as available assets. The attorney for the plaintiff submitted, at the hearing, an affidavit from herself dated February 8, 2021, stating that she had been the applicant's personal attorney since 1995, and that in her opinion, since 2013, the applicant was not able to understand, direct, transact or process any business matters and was not competent.3 The plaintiff did not submit any further evidence concerning the applicant's capacity. In her Final Decision upholding DSS's denial of Medicaid benefits, the hearing officer found that the Trust was revocable by the applicant and applicant spouse, the plaintiff had failed to prove that the applicant did not have the capacity to revoke the Trust, the Trust assets were properly found to be available and includable in the Medicaid calculations, and DSS properly denied the applicant's application for Medicaid benefits.

The plaintiff has now appealed the Final Decision to this court. The plaintiff is aggrieved because she appeals, on behalf of the deceased applicant, a final adverse decision of DSS denying long term care Medicaid benefits.

STANDARD OF REVIEW:

This appeal is brought pursuant to the Uniform Administrative Procedure Act (UAPA), General Statutes § 4-183.4 Judicial review of an administrative decision in an appeal under the UAPA is limited. Murphy v. Commissioner of Motor Vehicles, 254 Conn. 333, 343, 757 A.2d 561 (2000). “[R]eview of an administrative agency decision requires a court to determine whether there is substantial evidence in the administrative record to support the agency's findings of basic fact and whether the conclusions drawn from those facts are reasonable.... Neither [the Supreme Court] nor the trial court may retry the case or substitute its own judgment for that of the administrative agency on the weight of the evidence or questions of fact.... Our ultimate duty is to determine, in view of all of the evidence, whether the agency, in issuing its order, acted unreasonably, arbitrarily, illegally or in abuse of its discretion.” (Internal quotation marks omitted.) Id.

Although the courts ordinarily afford deference to the construction of a statute applied by the administrative agency empowered by law to carry out the statute's purposes, “[c]ases that present pure questions of law ... invoke a broader standard of review than is ... involved in deciding whether, in light of the evidence, the agency has acted unreasonably, arbitrarily, illegally or in abuse of its discretion.” (Internal quotation marks omitted.) Dept. of Public Safety v. Freedom of Information Commission, 298 Conn. 703, 716, 6 A.3d 763 (2010).

ANALYSIS:

Medicaid Title XIX is a social benefit program intended to be used by people who are incapable of caring for themselves and who do not have the resources to pay for the care they need. To meet these goals, Congress enacted provisions designed to ensure that only persons who are in fact poor and have not transferred assets that could have been used to pay for needed services, are provided the program's benefits. Medicaid eligibility determinations consider both income and assets. In general, an applicant may not have more than $1,600 in available assets in order to be eligible for Medicaid benefits.5 Eligibility for Medicaid benefits can only be confirmed when the applicant's applicable assets do not exceed the prescribed limit.

\*3 Under the applicable definitions, a resource is an asset (i) owned by the plaintiff, (ii) which can be converted to cash for use in supporting the plaintiff, and (iii) which the plaintiff is not legally restricted from using. See UPM § 4015.05P.6 Connecticut law provides that even if the foregoing three points are found, the plaintiff can still avoid having the asset counted against him if the plaintiff can prove that the asset was inaccessible. Thus, Connecticut law is more favorable to the plaintiff, since it provides an additional opportunity beyond the basic definition of a resource to avoid an asset being counted.

Connecticut General Statutes 17b-261 (c) provides in relevant part as follows:

“For 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 medical support....” (Emphasis added.)

Thus in order for an asset to be counted in an eligibility determination it must be “actually available” or the applicant must have the power “to obtain” it. These concepts are similar and look not solely to the legal title to the asset, but to the applicant's actual ability to get their hands on the asset (i.e. its actual availability to them or their power to obtain it). The provisions of UPM § 4015.05P dealing with the concept of inaccessibility consider the opposite side of the coin from the foregoing statute and place the burden of proof on the applicant.

In this case DSS determined that the total available resources of the applicant and applicant spouse were $440,419.80 and that Medicaideligibility could not be confirmed until the total countable assets were properly reduced to $128,0207 which comprised $1,600 in assets for the applicant and $126,420 for the applicant spouse as the “community spouse.”8 The foregoing determinations, made as of the applicable application date, resulted in DSS denying Medicaid benefits to the applicant for the period from December 2019 through September 2020. Since the applicant had passed away in August of 2020, the foregoing amounted to a complete denial of Medicaid benefits. In making its determinations, DSS included the value of assets in the Trust as available resources. It was this inclusion of the value of Trust assets that essentially precipitated the denial.

Accordingly, in the administrative hearing below and in this appeal, the primary issue is whether or not the Trust assets were available resources. This determination revolves around the terms of the Trust. The Trust provided that during the lives of the applicant and the applicant spouse, the trustees were to manage the Trust and distribute the Trust assets for the benefit of the applicant and applicant spouse in the discretion of the Trustees. The Trust further provided that the Trust was revocable, and the Trust assets could be removed, by the applicant and the applicant spouse, provided that they each had the mental capacity to do so, to the extent of each grantor's one-half share of the Trust.9 There is no doubt that the applicant spouse was competent and capable of terminating the Trust as to her half share thereof and removing assets equal to her half share from the Trust merely upon her determination to do so.

\*4 The plaintiff has taken the position that the applicant did not have the mental capacity to terminate the Trust and remove his share of the assets. If the applicant had the mental capacity to terminate the Trust and remove the Trust assets, then the Trust assets were available resources. Further, the applicant had the burden to prove his eligibility for Medicaid benefits, the inaccessibility of any asset, and any alleged incapacity. The sole evidence concerning the applicant's mental capacity was an affidavit and testimony from his personal lawyer expressing her personal opinion that the applicant was mentally incapacitated.10 In the administrative hearing below, the hearing officer accepted the affidavit as evidence, considered it and determined that it was insufficient evidence for her to conclude that the applicant was mentally incapacitated.11

The hearing officer was the trier of fact. Accordingly, she had the position to evaluate and weigh evidence, crediting and believing or discrediting and disbelieving pieces of evidence. Here, the hearing officer considered the affidavit and corresponding testimony and found it insufficient evidence to conclude that the applicant was mentally incapacitated. The affidavit was from the applicant's personal attorney, who was representing the plaintiff at the hearing and who was obviously advocating the position most favorable to the applicant, as any attorney would. While it was not absolutely required that medical evidence be submitted concerning the applicant's mental capacity, such medical evidence would have been more compelling. Further, while the attorney affidavit and testimony was some evidence, the evidence was not impartial12 and one could, but was not required to, reasonably question whether an attorney had the necessary skill and qualification to make such an assessment on her own. Accordingly, although the hearing officer could have credited the affidavit, it was not error for the hearing officer to find that the affidavit and corresponding testimony alone were insufficient evidence to conclude that the applicant was mentally incapacitated. The hearing officer's determination that the plaintiff had failed to prove that the applicant was mentally incapacitated meant that the Trust was revocable and the Trust assets were available resources which drove the applicant over the asset limit for Medicaid eligibility. In this regard, it must be noted that throughout the process, the plaintiff bore the burden of proof to prove eligibility for the Medicaid benefits and any alleged incapacity.

\*5 The plaintiff further asserts that DSS should have only included the applicant's half of the Trust assets. However, this position misses the following points. First, Medicaid looks at the assets of the applicant and the community spouse to determine whether the applicant's available resources exceed $1,600 and whether the community spouse's available resources exceed the maximum amount allowable for the community spouse. This is exactly what DSS did here. There is no doubt that the applicant spouse had the capacity and absolute authority and ability to revoke the Trust and remove her half of the assets. The hearing officer found that the applicant likewise had the capacity, authority and ability. Accordingly, the relevant Trust assets in question were properly includable in the calculations which DSS used to determine the maximum amount retainable by the applicant spouse as the community spouse. Further, even within the Trust, the assets were to be managed and distributed, subject to the Trustee's discretion, for the benefit and maintenance of each grantor, the applicant and applicant spouse.13

In view of the foregoing, the court finds that the plaintiff has failed to establish on appeal that the Final Decision was (1) in violation of constitutional or statutory provisions; (2) in excess of the statutory authority of the agency; (3) made upon unlawful procedure; (4) affected by other error of law; (5) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or (6) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion. Accordingly, the court must respectfully dismiss the appeal.

ORDER:

The appeal is dismissed.

All Citations

Not Reported in Atl. Rptr., 2022 WL 1585386

Footnotes

1

The Medicaid application was filed by the applicant himself and his representative, Karen Thorp. The applicant himself apparently signed the application. See page 16 of the record.

2

$126,420.00 for the applicant spouse plus $1,600 for the applicant.

3

The foregoing affidavit was not provided to DSS in the application process and the plaintiff had not challenged the applicant's capacity during the application process. The plaintiff's attorney also similarly testified at the hearing.

4

Section 4-183 (j) provides in relevant part: “The court shall not substitute its judgment for that of the agency as to the weight of the evidence on questions of fact. The court shall affirm the decision of the agency unless the court finds that substantial rights of the person appealing have been prejudiced because the administrative findings, inferences, conclusions, or decisions are: (1) In violation of constitutional or statutory provisions; (2) in excess of the statutory authority of the agency; (3) made upon unlawful procedure; (4) affected by other error of law; (5) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or (6) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion. If the court finds such prejudice, it shall sustain the appeal and, if appropriate, may render a judgment under subsection (k) of this section or remand the case for further proceedings.”

5

Medicaid benefits may only be provided if the applicant's available income and assets are below the prescribed eligibility limits. See General Statutes § 17b-80 (a). The relevant Medicaid asset limit is $1,600. See Uniform Policy Manual (UPM) § 4005.10 (A) (2) (a).

6

Legal restrictions can arise from things such as (i) an encumbrance or lien, (ii) joint owners of an account, or (iii) fiduciary obligations or trust terms associated with an account. In cases such as this, where a spouse remains in the community, specified regulatory consideration is given to an amount that is separately retainable by the spouse.

7

The non-residence property at 50 Biscayne Boulevard in Old Lyme was appraised at $260,700, which in and of itself would exceed the asset limit. The residence of the applicant spouse was not included in the foregoing determination.

8

A community spouse (i.e. a spouse who remains independent in the community) may retain an amount determined by an applicable regulatory scheme which lakes into account the assets and circumstances of the community spouse. To protect both the community spouse and the Medicaid program, detailed regulations have been put in place to determine the extent of assets and income that the community spouse may maintain while the institutionalized spouse receives Medicaid benefits. The effect of the foregoing community spouse regulations is not at issue in this appeal.

9

Regulations of Connecticut State Agencies § 17b-198-8 (l) (2) provides that “[t]he corpus of a trust shall be treated as a counted asset of a person ... if the terms of the trust permit such person to revoke the trust and receive the corpus of the trust upon revocation.” Such was the case here.

10

This affidavit was not submitted to DSS, and no challenge was made to the applicant's capacity, during the application process. UPM § 1010.05 requires the applicant to timely and accurately provide DSS with the information that it needs to determine eligibility and provides that the applicant bears the burden of proving eligibility. In this case, the applicant failed to timely attempt to challenge the applicant's capacity dining the application process, thereby depriving DSS an ability to evaluate the applicant's assertions. It was only later, after DSS had already denied the benefits and during the administrative hearing, that the applicant first attempted to challenge his capacity. During the application process DSS clearly provided the applicant with an opportunity to present all necessary evidence, ultimately advising the applicant that DSS intended to deny his application based upon excess assets unless the applicant provided documentation to dispute DSS's position. The applicant failed to timely dispute the DSS position by attempting to challenge capacity during the application process. It was readily apparent that DSS was including the 50 Biscayne Boulevard property in the available countable assets from the value of the available countable assets reported to the applicant by DSS. This failure is separately sufficient reason for the hearing officer to deny the applicant's application.

11

The court notes in this regard that the Medicaid application was actually filed by the applicant and his representative. The applicant signed the application himself. Further, the application specifically represented that the applicant did not have a disability or capacity issue through his signing the application and through his answers to specific questions. See the record at pages 16, 19, 20, and 22.

12

In this regard, not only was the attorney the applicant's long-time attorney, she was now actively representing the applicant's wife and the estate, and was expressing an opinion that would have an impact on the effectiveness of a trust that this attorney put in place for the applicant and the applicant spouse. Rule 3.7 of the Rules of Professional Conduct generally prohibits an attorney from testifying concerning and material issue of contested tact in a proceeding where the attorney is also acting as an advocate.

13

In this regard see UPM § 4030.80 (D) (1) through (3).