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

[redacted]
SIGNATURE CONFIRMATION

Client # [redacted]
Request # [redacted]

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] the Department of Social Services (the "Department") issued a Notice of Action ("NOA") to [redacted] (the "Appellant") stating that the Appellant's Community First Choice ("CFC") Individual Budget amount would be reduced from $63,108.00 to $50,310.00 per year, or from 68 hours per week of Personal Care Assistance ("PCA") to 52 hours per week of PCA, effective [redacted], based on a reassessment of the Appellant's level of need.

On [redacted], the Appellant requested an administrative hearing to contest the Department's reduction in his level of need.

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

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

The following individuals were present at the hearing:

[redacted], the Appellant
[redacted], the Appellant's daughter and PCA
Anna Karabin, Department's Community First Choice Representative
Katelyn Palermo, CFC Assessor, Western CT Area on Aging
Bonnie Sutherland, CFC Supervisor, Western CT Area on Aging

Maureen Foley-Roy, Hearing Officer

The hearing record remained open until [redacted] for the submission of additional evidence, a narrative of the assessment completed on [redacted] 2018. No comment was received from the Appellant. The record closed [redacted].

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department correctly reduced the Appellant's CFC service budget based on a reduction in the Appellant's level of need.

FINDINGS OF FACT

1. On [redacted], Department conducted a Community First Choice assessment and determined that the Appellant's level of need was a "5". The Department authorized an annual budget of $63,108, which was equivalent to approximately 68 hours of personal care assistance ("PCA") per week. (Hearing record and Exhibit 6: Notice of Action dated [redacted])

2. The Appellant is [redacted] years old and has diagnoses of diabetes, neuropathy, glaucoma and macular degeneration. The Appellant is blind. (Exhibit 1: Assessment dated [redacted])

3. The Appellant has no cognitive deficits and no behavioral issues. (Exhibit 1)

4. The Appellant lives with his wife and adult daughter. His adult daughter is one of two personal care attendants. His daughter is the only individual in the home who drives. She has a full time job. (Appellant's daughter's testimony)

5. On [redacted] Department conducted a reassessment of the Appellant's level of need and service plan, and determined that the Appellant needs extensive assistance with bathing, dressing and transferring. He needs cueing and supervision for eating and is independent with toileting. (Exhibit 5 Universal Assessment Outcome Form, [redacted])

6. The Appellant needs extensive assistance when bathing. He needs weight bearing support, including lifting of limbs. (Exhibit 1)

7. The Appellant manages personal hygiene with supervision and oversight. (Exhibit 1)

8. The Appellant needs limited assistance with dressing of his upper body. He needs guided maneuvering of limbs and physical guidance. (Exhibit 1)

9. The Appellant needs extensive assistance with dressing of the lower body. He

need weight bearing support due to weakness in his legs. (Exhibit 1)

10. The Appellant is totally independent with toileting. He does not need physical assistance, setup or supervision. (Exhibit 1)

11. The Appellant needs extensive assistance with transferring including weight bearing support with lifting limbs. (Exhibit 1)

12. The Appellant needs extensive assistance with walking, including weight bearing support. He uses a cane and a walker. (Exhibit 1, Appellant's testimony)

13. The Appellant needs limited assistance with eating. (Exhibit 1)

14. The Appellant needs maximal assistance with managing his medications. His blood sugars are unstable and they need to be monitored. Due to his blindness, he cannot inject his insulin. (Exhibit 1)

15. The others in the home do the shopping, housework, meal preparation and manage the finances. The Appellant's daughter provides transportation to medical appointments (Exhibit 1 and Appellant's daughter's testimony)

16. The Appellant needs set up assistance in order to use the telephone. (Exhibit 1)

17. The Appellant agrees with the assessment of [redacted] and understands why the hours were reduced based on that assessment. However, since that assessment was completed, the Appellant's issues with balance and transferring have deteriorated. He also reports that he is feeling depressed. The Appellant has not advised his primary physician of these changes but he has an appointment scheduled and plans to make his doctor aware of them. (Appellant and his daughter's testimony)

18. The issuance of this decision is timely under Connecticut General Statutes § 17b-61(a), which requires that a decision be issued within 90 days of the request for an administrative hearing. The Appellant requested an administrative hearing on [redacted]. Therefore, this decision was due not later than [redacted] The hearing record was anticipated to close on [redacted] The Appellant and the hearing officer agreed at the hearing that the record would remain open for the submission and review of the visit note. The hearing record closed on [redacted]. Because of this 29 day delay in the close of the hearing record, the final decision is not due until [redacted] and is therefore timely.

CONCLUSIONS OF LAW

1. The Department is the state agency for the administration of the Medicaid program pursuant to Title XIX of the Social Security Act. The Commissioner may make such regulations as are necessary to administer the medical assistance program. [Conn. Gen. Stat. § 17b-2; Conn. Gen. Stat. § 17b-3]

2. Title 42 of the Code of Federal Regulations ("CFR") § 441.500 (a) provides that this subpart implements section 1915(k) of the Act, referred to as the Community First Choice Option (hereafter Community First Choice), to provide home and community-based attendant services and supports through a State plan.

3. 42 CFR § 441.500 (b) provides Community First Choice is designated to make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands-on assistance, supervision, or cueing.

4. 42 CFR § 441.505 provides for definitions and states in part that Activities of daily living (ADLs) means basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring. Instrumental activities of daily living (IADLs) means activities related to living independently in the community, including but not limited to, meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.

5. 42 CFR § 441.535 provides for Assessment of functional need. States must conduct a face-to-face assessment of the individual's needs, strengths, preferences, and goals for the services and supports provided under Community First Choice in accordance with the following:

    (a) States may use one or more processes and techniques to obtain information, including telemedicine, or other information technology medium, in lieu of a face-to-face assessment if the following conditions apply:

        (1) The health care professional(s) performing the assessment meet the provider qualifications defined by the State, including any additional qualifications or training requirements for the operation of required information technology;
        (2) The individual receives appropriate support during the assessment, including the use of any necessary on-site support-staff; and
        (3) The individual is provided the opportunity for an in-person assessment in lieu of one performed via telemedicine.

(b) Assessment information supports the determination that an individual requires Community First Choice and also supports the development of the person-centered service plan and, if applicable, service budget.

(c) The assessment of functional need must be conducted at least every 12 months, as needed when the individual's support needs or circumstances change significantly necessitating revisions to the person- centered service plan, and at the request of the individual.

(d) Other requirements as determined by the Secretary.

The Department correctly completed an assessment through its contractor to determine the Appellant's service plan and service budget.

6. 42 CFR § 441.510 address eligibility for the program as follows:

To receive Community First Choice services and supports under this section, an individual must meet the following requirements:

(a) Be eligible for medical assistance under the State plan;

(b) As determined annually-

(1) Be in an eligibility group under the State plan that includes nursing facility services; or

(2) If in an eligibility group under the State plan that does not include such nursing facility services, have an income that is at or below 150 percent of the Federal poverty level (FPL). In determining whether the 150 percent of the FPL requirement is met, States must apply the same methodologies as would apply under their Medicaid State plan, including the same income disregards in accordance with section 1902(r)(2) of the Act; and,

(c) Receive a determination, at least annually, that in the absence of the home and community-based attendant services and supports provided under this subpart, the individual would otherwise require the level of care furnished in a hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over, if the cost could be reimbursed under the State plan. The State administering agency may permanently waive the annual recertification requirement for an individual if:

(1) It is determined that there is no reasonable expectation of improvement or significant change in the individual's condition because of the severity of a chronic condition or the degree of impairment of functional capacity; and

(2) The State administering agency, or designee, retains documentation of the reason for waiving the annual recertification requirement.

(d) For purposes of meeting the criterion under paragraph (b) of this section, individuals who qualify for medical assistance under the special home and community-based waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Act must meet all section 1915(c) requirements and receive at least one home and community-based waiver service per month.

(e) Individuals receiving services through Community First Choice will not be precluded from receiving other home and community-based long-term care services and supports through other Medicaid State plan, waiver, grant or demonstration authorities.

7. 42 CFR § 441.520 provides for included services as follows:

(a) If a State elects to provide Community First Choice, the State must provide all of the following services:

(1) Assistance with ADLs, IADLs, and health-related tasks through hands-on assistance, supervision, and/or cueing.

(2) Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks.

(3) Backup systems or mechanisms to ensure continuity of services and supports, as defined in § 441.505 of this subpart.

(4) Voluntary training on how to select, manage and dismiss attendants.

The Department correctly determined that the Appellant needs extensive assistance with bathing, dressing and transferring, and supervision with eating.

The Department correctly determined that the Appellant needs assistance, supervision and cueing for his IADL's.

8. Title 42 CFR § 441.540 (b)(5) provides that the person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under Community First Choice, the plan must reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports cannot supplant needed paid services unless the natural supports are unpaid supports that are provided voluntarily to the individual in lieu of an attendant.

   Connecticut State Plan Amendment ("SPA") no.15-012, pursuant to section 1915(k) of the Social Security Act, 5 A provides for limits on amount, duration or scope of included services. It states that the Department assigns an overall budget based on need grouping that is determined by algorithm and that natural supports are based on the individual's functional assessment, which will take into consideration the availability of natural supports. Natural supports are identified during the person centered service planning process and utilized when available to the individual. Natural supports are defined as voluntary unpaid care provided on a regular and consistent basis by a parent, spouse or other person.

   The Department correctly determined that the Recipient's family is a source of natural support for his ADLs and IADLs.

9. Title 42 CFR§ 441.510 (e)provides that individuals receiving services through Community First Choice will not be precluded from receiving other home and community-based long-term care services and supports through other Medicaid State plan, waiver, grant or demonstration authorities.

10. For the purposes of the administration of the medical assistance programs by the Department, "medically necessary" and "medical necessity" mean those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an

assessment of the individual and his or her medical condition. [Conn. Gen. Stat. § 17b-259b (a)]

Based on the evidence provided at the September assessment, there is no evidence that the reduction in the Appellant's weekly PCA hours from 68 hours per week to 52 hours per week is not adequate to meet the Appellant's functional needs with regards to his medical condition and overall health.

Based on the evidence provided, there is no medical evidence that the reduction in the Appellant's weekly PCA hours and budget service plan places the Appellant at immediate risk of institutionalization.

The Department correctly determined that the Appellant is eligible for 52 hours per week of CFC services.

DISCUSSION

Testimony at the hearing by both the Appellant and his daughter indicated that they understood the reduction in hours as based upon the Department's September assessment. The testified to deterioration in the Appellant's mental/emotional state and also a new unsteadiness in his gait since that time. The Appellant was advised to contact his primary care provider regarding the changes. If there has been a change in the Appellant's condition a new assessment may be warranted.

DECISION

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

Maureen Foley-Roy,
Hearing Officer

CC: Anna Karabin, DSS, Central Office
Sallie Kolreg, DSS, Central Office
Dawn Lambert, DSS, Central Office

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 06105-3725.

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.