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 Id: # [redacted]
Hearing Id: # [redacted]

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2017, the Department of Social Services (the "Department") discontinued [redacted] (the "Appellant") Home Care Waiver Medicaid Assistance ("W01").

On [redacted], 2017, the Appellant requested an administrative hearing to contest the Department's action to discontinue her Medicaid assistance.

On [redacted] 2017, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2018.

On [redacted] 2018, the Appellant requested her administrative hearing be rescheduled as a home hearing.

On [redacted] 2018, the OLCRAH issued a notice scheduling the administrative hearing for [redacted] 2018.

On [redacted] 2018, 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], the Appellant

Paul Chase, Department's Representative
Scott Zuckerman, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department's decision to discontinue the Appellant's Home Care Waiver Medicaid Assistance was correct.

FINDINGS OF FACT

1. The Appellant is [redacted] years old ([redacted]) and an assistance unit of one. (Hearing Record and Appellant's testimony)

2. The Appellant resides alone. (Hearing Record and Appellant's testimony)

3. The Appellant meets the nursing home level of care requiring assistance with Activities of Daily Living ("ADL") (Department's testimony)

4. On [redacted] 2015, the Department discontinued the Appellant's Personal Care Assistant ("PCA") Waiver effective [redacted]/15 for the reason, "you have demonstrated an inability to self-direct your PCAs. (Exhibit 1: Notice of Action. [redacted]/15)

5. The Appellant requested an administrative hearing regarding the denial of the PCA waiver. The Department was upheld in their decision to deny the PCA waiver. (Appellant's testimony, Department's testimony)

6. The Appellant continued to receive Home Care Waiver Medicaid despite not receiving any home or community based services under a waiver. (Appellant's testimony, Department's testimony)

7. Sometime in the fall of 2016, the Appellant was approved for home and community based services through the Community First Choice program. (Appellant's testimony, Department's testimony)

8. The Community First Choice program is a state plan waiver option, which allows the Appellant to self-manage hiring PCAs. It has a service within that program to assist in self-directing the PCA's. (Department's testimony)

9. The Appellant must be active on Medicaid to receive services through the Community First Choice program. (Department's Testimony)

10. The Appellant was able to successfully self-manage her PCA through the Community First Choice program. (Department's Testimony)

11. On [redacted] 2017, the Department sent the Appellant a Notice of Action stating the Appellant's Husky C – Individual Receiving Home and Community Based Services Medicaid was discontinued effective [redacted]/17. The notice stated the reason for the discontinuance was "Does not meet program requirements, no household members are eligible for this program. In addition, the notice informed the Appellant that her medical coverage changed to Husky C – Medically Needy Aged, Blind, and Disabled – Spenddown. The Appellant was not eligible for medical coverage because her income is too high and she must meet a spenddown of $1,581.72 to be eligible for Medicaid. (Exhibit 3: Notice of action, [redacted]17)

CONCLUSIONS OF LAW

1. Section 17b-2 of the Connecticut General Statutes authorizes the Commissioner of the Department of Social Services to administer the Medicaid program.

2. Title 42 of the Code of Federal Regulations ("CFR"), Part 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.

3. Community First Choice State Plan Option Pursuant to Section 1915(k) of the Social Security Act provides the following:

1. <u>Eligibility</u>

A. The State determines eligibility Community First Choice (CFC) services in the manner prescribed under 42 CFR § 441.510. To receive CFC services and supports under this section, an individual must be eligible for medical assistance under the State plan, and must be in an eligibility group that includes nursing facility services or must have income below 150% of the Federal Poverty Level (“FPL”) if they are in an eligibility group that does not include Nursing Facility services.

Individuals who are receiving medical assistance under the special home and community-based waiver eligibility group defined at section l902(a)(10)(A)(ii)(VI) of the Act must continue to meet all 1915(c) requirements and must receive

at least one home and community-based waiver service per month. Individuals receiving services through CFC will not be precluded from receiving other home and community-based long-term services and supports through the Medicaid State plan, waiver, grant or demonstration but will not, be allowed to· receive duplicative services as between CFC and any other available source of Medicaid coverage for home and community-based services.

4. Uniform Policy Manual ("UPM") 2540.01 (A) provides in order to qualify for Medicaid; an individual must meet the conditions of a least one coverage group.

   UPM § 2540.01 (D) provides, unless otherwise stated in particular coverage group requirements, all individuals must meet the MA technical and procedural requirements to be eligible for Medicaid.

5. UPM § 2540.92 (A) provides individuals receiving home and community based services includes individuals who:

   1. would be eligible for MAABD if residing in a long term care facility ("LTCF"); and
   2. qualify to receive home and community-based services under a waiver approved by the Centers for Medicare and Medicaid Services; and
   3. would, without such services, require care in an LTCF.

   UPM § 2540.92 (B) provides individuals qualify for Medicaid as categorically needy for as long as they meet the conditions above and receive home and community-based services under a waiver.

6. The Appellant meets the criteria for nursing home level of care.

7. Because the Appellant was approved and qualified for PCA services through the Community First choice program and she has demonstrated that she is able to self-manage her PCAs, the Department incorrectly discontinued the Appellant's Home Care Waiver Medical Assistance program based on a determination from [redacted] 2015 that she is not capable of self-managing her PCAs.

8. The Department has failed to prove that the Appellant does not meet the requirements for services under the Home Care Waiver Medical Assistance (W01) program.

DECISION

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

ORDER

1. The Department will reinstate the Appellant's Home Care Waiver Medicaid assistance effective [redacted] and continue to process her case to determine ongoing eligibility for the waiver program.

2. Compliance with this order is due to the undersigned no later than [redacted] 2018.

_____
Scott Zuckerman
Hearing Officer

Cc: Paul Chase, DSS, Central Office
Shirlee Stoute, DSS, Central Office
Lisa Bonetti, DSS, Central Office
Laurie Filippini, DSS, Central Office
Pam Adams, 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, law, and 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, if 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 06105-3725. 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.