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

[redacted] 2018
Signature Confirmation

Client ID # [redacted]
Request # [redacted]

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2018, the Department of Social Services' ("Department"), Community First Choice ("CFC"), hand delivered [redacted] ("Appellant") a notice stating that she does not meet the level of care criteria to be eligible for services under CFC.

On [redacted] 2018, the Appellant requested an administrative hearing to contest the Department's CFC decision.

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

On [redacted] 2018, in accordance with sections 17b-60, 17-61 and 4-176e to 4-189 inclusive, of the Connecticut General Statutes, OLCRAH held an administrative hearing at [redacted] CT.

The following individuals were present at the hearing:

[redacted], Appellant
[redacted], Personal Care Attendant, Allied Community Resources
Erin Kane, Connecticut Community Care, Inc. ("CCCI"), by phone
Dawn Lambert, Department of Social Services, Community Options
Scott Zuckerman, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department's decision to discontinue the CFC services because she no longer meets the nursing facility level of care was correct.

FINDINGS OF FACT

1. The Appellant is a [redacted] years old and lives independently in her own apartment. (Hearing Record)

2. The Appellant is a Husky C Medicaid recipient. (Hearing Record)

3. On [redacted], 2016, the Appellant applied for CFC services. (Hearing Record)

4. On [redacted], 2016, the Appellant completed an assessment for the CFC services. (Hearing Record)

5. On [redacted] 2016, the Department approved the Appellant's initial service plan with a budget. (Hearing Record)

6. The Appellant was receiving services under an approved plan when the eligibility for the CFC services was redesigned to meet new federal guidelines to implement the revised Universal Assessment. (Hearing Record)

7. The Department sent a letter to all CFC applicants and participants explaining the potential impact of the redesign on their service plan and benefit. All individuals will be reassessed under the new rules. (Hearing Record, Exhibit 5: CFC Notice of Reassessment)

8. CCCI is the Department's contractor for the purpose of assessing level of care and service needs for CFC services. (Hearing Record)

9. On [redacted] 2018, a UCM from CCCI met with the Appellant at her home and completed a revised Universal Assessment. (Hearing Record, Exhibit 1: Universal Assessment Outcome form, Ex. 7:Universal Assessment, [redacted]/18)

10. The Appellant's primary diagnosis is [redacted]. (Hearing Record)

11. The Appellant has Osteoarthritis and receives active treatment. (Ex. 7)

12. The Appellant is diagnosed with Neuropathy and receives active treatment. (Ex. 7)

13. The Appellant is diagnosed with Asthma and receives treatment. (Ex. 7)

14. The Appellant is diagnosed with [redacted] and receives treatment. (Ex. 7)

15. The Appellant is diagnosed with [redacted]. (Ex. 7)

16. The UCM determined the Appellant's cognitive status as alert and oriented. (Exhibit 2: Universal Assessment Outcome Form)

17. The UCM determined the Appellant is Independent with the following Activities of Daily Living ("ADL"): toileting, transferring and eating. (Exhibit 1)

18. The UCM determined that the Appellant needs extensive assistance for bathing. The Appellant's Personal Care Assistant ("PCA") assists with the task. (Appellant's testimony, Exhibit 1)

19. The Appellant is at risk of scalding herself while bathing due to [redacted] (Ex. 7)

20. The Appellant requires some assistance with dressing. The PCA helps her put on her shirt, articles of clothing are placed within reach. (Appellant's testimony, PCA testimony, Exhibit 7, Universal Assessment, [redacted]/18)

21. The Appellant is independent in using the toilet. (Appellant's testimony, Exhibit 7, Universal Assessment)

22. The Appellant walks around her apartment with the assistance of a cane. (Appellant's testimony, Ex. 7)

23. The Appellant requires assistance moving around in the community. (Ex. 7)

24. The Appellant is independent with transferring. (Appellant's testimony, Ex. 7)

25. The Appellant requires assistance in going up and down stairs. (Ex. 7)

26. The Appellant is dependent on others for meal preparation. (Ex. 7)

27. The Appellant is at risk of leaving burners on when preparing meals due to [redacted] (Ex.7)

28. The Appellant requires assistance shopping for food and household items. (Ex. 7)

29. The Appellant is able to eat independently. (Appellant's testimony, Ex. 7)

30. The Appellant requires extensive assistance in managing her medications. The Appellant requires set up to take her medications. (Ex. 7)

31. The Appellant requires assistance with housework. (Ex. 7)

32. The Appellant requires maximal assistance in managing her finances. (Ex. 7)

33. On [redacted] 2018, the Department gave the Appellant a Notice of Action ("NOA"), Community First Choice Service Budget Reduction letter. The letter stated that the Department previously authorized a CFC Individual budget of $55,848.00. The revised CFC Individual Budget is $0.00. (Hearing Record, Exhibit 3: NOA dated [redacted]/18)

34. The Appellant requires assistance with following: 2 ADLs, dressing bathing and supervision and assistance with 4 Instrumental ADLs, meal preparation, housework, grocery shopping, and managing medications. (Appellant's testimony, Exhibit 1 and Exhibit 7) (see Findings of Fact # 27-32)

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") § 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. Title 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. Title 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. Title 42 CFR § 441.510 provides 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 dis- regards 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;
      (2) The State administering agency, or designee, retains documentation of the reason for waiving the annual re- certification 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.

6. Title 42 CFR§ 441.520 (a) provides for included services and states that 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, <u>supervision, and/or cueing</u>**. (Emphasis added)

7. 42 C.F.R. § 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.

8. State Plan Under Title XIX of The Social Security Act states: Community First Choice State Plan Option Pursuant to Section 191S(k) of the Social Security Act

1. Eligibility

A. The State determines eligibility for Community First Choice (CFC) services in the manner prescribed under 42CFR § 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 l 902(a)(lO)(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. (Attachment 3.1-K, Page 1 of 23)

9. Section 17b-259b of the Connecticut General Statures states that "Medically necessary" and "medical necessity" defined. Notice of denial of services. Regulations.

(a) For purposes of the administration of the medical assistance programs by the Department of Social Services, "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.

a. Clinical policies, medical policies, clinical criteria or any other generally accepted clinical practice guidelines used to assist in

> evaluating the medical necessity of a requested health service shall be used solely as guidelines and shall not be the basis for a final determination of medical necessity. (c) Upon denial of a request for authorization of services based on medical necessity, the individual shall be notified that, upon request, the Department of Social Services shall provide a copy of the specific guideline or criteria, or portion thereof, other than the medical necessity definition provided in subsection (a) of this section, that was considered by the department or an entity acting on behalf of the department in making the determination of medical necessity.

The Appellant has uncontrolled and/or unstable conditions requiring nursing services. The Appellant requires hands on assistance for bathing and dressing herself. The Appellant requires set up for her medications due to her [redacted]

The Appellant requires the level of care furnished in a nursing facility in the absence of the home and community-based attendant services and supports as stated in Title 42 CFR § 441.510.

CCCI is incorrect in its determination that the Appellant does not require the level of care furnished in a nursing facility. The Appellant requires hands on assistance with 2 or more ADLs, plus one need factor.

DECISION

The Appellant's appeal is **GRANTED**

ORDER

1. The Department will consider that the Appellant meets the LOC for CFC Services and will direct CCCI to reassess the Appellant's needs and issue an updated budget based on her needs.

2. Compliance with this order is due by [redacted] 2018 and will consist of documentation of the Appellant's updated budget.

Scott Zuckerman
Hearing Officer

C: Sallie Kolreg, DSS – Central Office
Lisa Bonetti, DSS – Central Office
Dawn Lambert, DSS – Central Office
Christine Weston, 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.

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.