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 # 117395

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

[redacted], 2018, the Department of Social Services' ("Department"), Community First Choice ("CFC"), sent [redacted] ("Appellant") a notice stating that she does not meet the level of care criteria to be eligible for CFC Individual Budget program.

[redacted], 2018, the Appellant requested an administrative hearing to contest the Department, 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]

The following individuals were present at the hearing:

[redacted], Appellant
Donna Grieder, Universal Care Manager ("UCM"), Connecticut Community Care, Inc. ("CCCI")
Dawn Lambert, Department of Social Services, Program Manager
Miklos Mencseli, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department was correct to reduce the Appellant's Community First Choice (CFC) budget from $41,880.00 to $0.00 effective [redacted] 2018 because she does not meet the level of care criteria.

FINDINGS OF FACT

1. The Appellant is receiving Medicaid for Employed Disabled ("S05") benefits. (Hearing Record)

2. On [redacted] 2017, the Appellant applied for Community First Choice ("CFC") program. (Hearing Record)

3. On [redacted] 2017, the Appellant completed an assessment for the CFC program. (Hearing Record, Exhibit 10: Universal Assessment form)

4. On [redacted], 2017, the Department approved an initial service plan with a budget for the Appellant. (Hearing Record)

5. The Appellant was in the process of hiring staff when the CFC program was temporarily stopped to be redesigned to meet new federal guidelines and to implement the revised Universal Assessment program. (Hearing Record)

6. The Department sent a letter to all CFC pending applicants and Individuals receiving CFC services 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 7: CFC Notice of Reassessment)

7. On [redacted], 2018, a UCM from CCCI did a home visit and completed an updated Universal Assessment Outcome form for the Appellant. (Hearing Record, Exhibit 9: Universal Assessment Outcome form)

8. On [redacted], 2018, the Department gave the Appellant a Notice of Action ("NOA") denial letter stating her CFC Individual Budget is $0.00. (Hearing Record, Exhibit 8: NOA dated [redacted]-18)

9. The UCM determined the Appellant is Independent with the with the following Activities of Daily Living ("ADL"): bathing, dressing, toileting and eating. The Appellant needs supervision/cueing for transferring. The Appellant is cognitive, oriented and does not need Medication Supports beyond set-up as Need Factor Results. (Exhibit (9)

10. The Appellant's primary diagnosis is blindness, diabetes and neuropathy. The Appellant also suffers from carpal tunnel. (Hearing Record, Exhibit 9)

11. The Appellant is a [redacted] year old individual who lives independently in her own apartment. (Hearing Record)

12. The Appellant is legally blind, total blindness in left eye and partial in right eye. (Hearing Record, Exhibit 10)

13. The Appellant is employed by the [redacted] The Appellant works 40 hours per week. (Hearing Record)

14. The Appellant is seeking some help with meal preparation, house cleaning, picking out her clothes and help when food shopping. (Appellant's Testimony)

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) § 441.510 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 in- come 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 re- certification 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 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.

3. 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 op- portunity 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.

4. 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.

(b) 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.

5. Based on the new assessment the Appellant does not meet the criteria to be eligible for the CFC program.

6. The Appellant has the physical ability to complete her ADLs.

7. The Appellant does not meet the criteria of an individual who requires institutional level of care.

8. CCCI is correct in its determination that the Appellant does not meet the medical criteria to be eligible under the State plan for Community First Choice services.

DISCUSSION

The Appellant is independent with her ADLs. The Appellant lives independently in her own apartment. The help she is requesting is not considered ADL items for the CFC services. The Appellant needs assistance with meal preparation, house cleaning, picking out her clothes and help when food shopping. The Appellant had one area rated; supervision/cueing for transferring.

DECISION

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

Miklos Mencseli
Hearing Officer

C: Dawn Lambert, DSS – Central Office
Shirlee Stoute, DSS – Central Office
Paul Chase, DSS – Central Office
Lisa Bonetti, DSS – Central Office
Laurie Filippini, DSS – Central Office
Pamela J 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 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.