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

[redacted] **2018**
**Signature Confirmation**

Case ID# [redacted]
CL ID# [redacted]
Request# [redacted]

## NOTICE OF DECISION

## PARTY

[redacted]

## PROCEDURAL BACKGROUND

On [redacted] 2018, the Department of Social Services (the "Department") issued a Notice of Action ("NOA") to [redacted] (the "Appellant") indicating that the Appellant's Community First Choice ("CFC") Individual Budget amount would be reduced from $55,848.00 to $25,473.90 per year, from 56.00 hours per week of Personal Care Assistance ("PCA") to 30.25 hours per week of PCA, effective [redacted] 2018, based on a reassessment of the Appellant's level of need.

On [redacted] 2018, the Appellant requested an administrative hearing to contest the Department's to take such action.

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

The following individuals were present at the hearing:

[redacted] Appellant
Appellant's Witness, [redacted] Personal Care Attendant ("PCA")
[redacted]
Christine Weston, Department's Representative
Sybil Hardy, Hearing Officer

The hearing record remained open for the submission of the correct date of original application and the summary of the Appellant's budget. On [redacted] 2018, the hearing record closed with no additional information received.

On [redacted] 2018, the hearing record was reopened to enter a revised copy of the hearing summary with the correct application date and charts explaining the level of need and activities of daily living budget calculations.

The record remained opened to allow the Appellant time to respond to the additional information submitted by the Department. On [redacted] 2018, the hearing record closed with no response from the Appellant.

## STATEMENT OF THE ISSUE

The issue is whether the Department correctly reduced the Appellant's CFC service budget based on the Appellant's current level of need.

## FINDINGS OF FACT

1. On [redacted] 2016, the Department conducted an assessment of the Appellant's level of need and determined that the Appellant required assistance with her activities of daily living ("ADLs") and her instrumental activities of daily living ("IADLs"). (Hearing Summary)

2. On [redacted] 2017, the Department approved the Appellant's service plan of $55,126.86 allowing her to receive 56 hours per week of PCA. (Appellant's Testimony, Hearing Summary, Exhibit 2: Revised CFC Individual Budget and Universal Assessment Outcome Form)

3. The Department redesigned the eligibility for CFC services to meet new federal guidelines and to implement a revised Universal Assessment. The Department contracted with the [redacted] to determine level of care needs and service plan budgets. (Hearing Record, Exhibit 3: Disclosure Information, [redacted]/18)

4. The Department's revised Universal Assessment guidelines standardized the assessment process by linking clinical responses to assessment questions and using clinical criteria to determine the level of care and service needs budgets. (Hearing Summary)

5. On [redacted] 2018, WCAAA conducted a reassessment of the Appellant's level of need and service plan, and determined that the Appellant needed extensive assistance with bathing, limited assistance with dressing, cueing and supervision with toileting and independent with eating and transferring in the community. (Exhibit 2)

6. The Appellant's Level of Need was scored at 3 and she was determined to need nursing facility ("NF") level of care. (Exhibit 2)

7. The Appellant has a medical diagnosis of Arthritis, Diabetes and Sleep Apnea. (Appellant's Testimony, Exhibit 2)

8. The Appellant is 62 years of age [redacted] (Appellant's testimony; Hearing Summary)

9. The Appellant has made adaptions and improvements since her previous assessment. (Department Representative's Testimony)

10. The Appellant walks with the assistance of a walker. (Appellant's Testimony)

11. The Appellant is able to complete 50 percent of the bathing on her own. (UCM's Testimony)

12. The Appellant can dress the upper portion of her body with setup assistance. (Appellant's Testimony, UCM's Testimony)

13. The Appellant is unable to dress the lower portion of her body without assistance. (Appellant's Testimony)

14. The Appellant has grab bars on her bed to assist with getting out of bed. (UCM's Testimony)

15. The Appellant previously required assistance with toileting but now uses a raised toilet seat and a commode to assist with toileting. (UCM's Testimony)

16. The Appellant's cognitive status is alert and oriented. (Exhibit 2)

17. The Appellant has no behavioral concerns. (Exhibit 2)

18. The Appellant does not require medication supports beyond set-up. (Exhibit 2)

19. The Appellant lives alone in her own apartment. (Appellant's testimony)

20. The Appellant is responsible for hiring PCA staff and arranging their work schedule. (Exhibit 2)

21. PCAs may assist the Appellant with ADLs, IADLs and health related tasks. (Exhibit 2)

22. The Appellant hired [redacted] to be one of her PCAs. (Appellant's Testimony, Appellant's Witness' Testimony)

23. On [redacted] 2018, the Department issued a NOA to the Appellant informing her that the revised funding appropriate to her level of need was $25,473.90 per year, effective [redacted], 2018, because her PCA hours were reduced from 56 hours per week to 30.25 hours per week. (Exhibit 1: NOA, [redacted]18, Exhibit 2)

24. The Appellant allocates her weekly PCA hours to two aides to assist her in the home with completing her ADLs and IADLs. (Appellant's testimony)

25. During [redacted], the Appellant had two medical procedures that did not require hospitalization or continued nursing care but she was unable to be alone 24 hours due the effects of anesthesia. (Appellant's Testimony)

## 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 § 441.510 address eligibility for the CFC 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.

6. 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 provides that:

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.

7. 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 as assessment through its contractor to determine the Appellant's service plan and service budget.**

8. 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.

**Based on the evidence provided, the reduction in the Appellant's weekly PCA hours from 56 hours per week to 30.25 hours per week is adequate to meet the Appellant's functional needs with regards to her medical condition and overall health. The Appellant has made improvements in independently transferring. She only requires cueing and supervision with toileting. The Department correctly determined that the Appellant needs extensive assistance with bathing and limited assistance with dressing and**

**cueing and supervision with toileting.**

**The Department correctly determined that 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 reduction in the Appellant's weekly PCA hours from 56 hours to 30.25 hours per week still provides for the welfare and safety of the Appellant in her home.**

## DECISION

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

Sybil Hardy
Hearing Officer

Pc: 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 06105-3725.

## 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.