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

Client ID # [REDACTED]
Request # 118819

NOTICE OF DECISION

PARTY

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

On [REDACTED], 2018, the Department of Social Services, (the "Department"), hand delivered [REDACTED] (the "Appellant's mother") a Notice of Action ("NOA") reducing the Community First Choice ("CFC") budget for her daughter [REDACTED] (the "Appellant") based on a reassessed level of need.

On [REDACTED] 2018, the Appellant's mother requested a hearing to contest the reduction.

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, the Appellant requested a reschedule of the administrative hearing.

On [REDACTED], 2018, OLCRAH issued a notice rescheduling 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.

The following individuals were present at the hearing:

Appellant's mother
, Appellant's mother's witness
Dawn Lambert, Department's representative, Manager, Community First Choice
Marci Ostroski, Hearing Officer

The Appellant has limited verbal skills and did not participate in the hearing due to her diagnoses of intellectual disability and autism.

The Hearing Record remained open until 2018 for the submission of additional documentation from the Appellant and the Department. Exhibits were received from the Appellant and forwarded to the Department. The Department requested an extension of time to provide their additional documentation and to respond to the Appellant's new exhibits. The Hearing Record was extended until 2018 for the Department and until , 2018 for the Appellant to reply to the Department. The Department did not provide the additional documents or respond to the Appellant's exhibits. The Record closed , 2018.

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department was correct to reduce the Appellant's CFC budget.

FINDINGS OF FACT

1. The Appellant receives Medicaid services through the State of Connecticut Department of Developmental Disabilities ("DDS") waiver program. The Appellant is twenty two years old and has an intellectual disability since birth. She has also been diagnosed with autism, GERD, asthma, liver disorder, and high cholesterol. (Hearing Summary, Department's testimony, Appellant's mother's testimony)

2. The Appellant was granted services under the Community First Choice ("CFC") program to provide support for her activities of Daily living ("ADLs") instrumental activities of daily living ("IADLs") and health related tasks. (Hearing Summary, Department's testimony)

3. The Appellant was assessed for her needs on , 2017, and approved for 64 hours per week of PCA services within the annual budget of $56809.45 under the CFC program. (Department's testimony, Ex. 6: Notice of

Action, ▇▇/18, Ex. 8: CFC Budget Approval Form, Ex. 10: CFC Budget Worksheet)

4. In ▇▇ 2017, the Appellant participated in an annual comprehensive reassessment for Medicaid long term supports and services by DDS. (Hearing Summary)

5. On ▇▇ 2018, the CFC program reviewed the DDS reassessment and completed an annual face to face assessment of need specifically related to core ADLs that were not included in the DDS reassessment. (Hearing Summary)

6. The Department determined that for the ADLs, the Appellant requires maximum assistance with bathing, extensive assistance with dressing, cueing and supervision with toileting and grooming and that she was independent with eating and transferring. (Hearing Summary, Ex. 6: Universal Assessment Outcome Form)

7. The Department determined that for IADLs the Appellant requires assistance with taking medications, using the telephone, household chores, budgeting, meal preparation, and shopping. (Hearing Summary)

8. The Appellant receives individual day supports through the DDS waiver. The Appellant receives DDS services Monday through Friday from 8:00am to 12:00pm four hours a day, for a total of 20 hours per week (4 hours x 5 days) in which her mother, as a DDS support worker, provides her with independent living skills and vocational preparation at the library and exercise that the YMCA. (Appellant’s mother’s testimony)

9. The Appellant’s mother has been using the CFC services to hire Personal Care Assistants (“PCA”) and to act as a PCA to assist and supervise the Appellant for the time when she is not in the DDS program. (Appellant’s testimony, Hearing summary)

10. The Appellant’s PCAs provide services Monday through Friday from 12:00pm to 5:00pm and 5:00pm to 9:00pm for a total of 45 hours a week. (5 hours + 4 hours=9 hours a day X 5 days). (Appellant’s mother’s testimony)

11. On ▇▇ 2018, the Department determined based on the DDS reassessment and the CFC face to face assessment that that Appellant is eligible for an annual budget of $41,152 for all services related to her ADLs, IADLs, and health related tasks provided by DDS and CFC. (Hearing Summary, Department’s testimony)

12. The Department determined that the Appellant required 17.5 hours per week of PCA services under the CFC program. (Hearing Summary, Department's testimony, Ex. 6: Notice of Action)

13. The Department determined that based on 25.75 hours per week of DDS services she was receiving a budget of $24,502 from DDS. The Department subtracted the $24,502 from the $41,152 that they determined she was eligible for and calculated that she was eligible for $16,650 (41152-24502) from the CFC program to address her ADL needs. (Hearing Summary, Department's testimony)

14. The Appellant is not receiving 25.75 hours of DDS services. (Appellant's testimony, Fact 8)

15. The Department miscalculated the amount of services that the Appellant was eligible for based on the miscalculation of DDS services. (Department's testimony)

16. On [redacted], 2018, the Department visited the Appellant's home and hand delivered a notice to her mother advising that her CFC Individual budget was being reduced from $56,809.45 to $14,736.96 equaling 17.5 hours of PCA services per week effective [redacted], 2018. (Ex. 6: Notice of Action)

17. The Department's hearing summary, exhibits and testimony lacked evidence as to how the 17.5 hours per week was calculated. (Hearing record)

18. On [redacted], 2018, the Appellant's mother and the Department participated in an administrative hearing. (Hearing record)

19. At the administrative hearing the Department stated that the CFC budget would be recalculated based on the Appellant's mother's testimony that the Appellant was only receiving 20 hours of DDS services a week and a new notice of action would be issued. (Department's testimony)

20. After the administrative hearing, on [redacted], 2018, the Appellant submitted additional medical documentation for the Department's review. The information was forwarded to the Department. On [redacted] [redacted] 2018 the Department requested an extension to review the documentation and explore the recalculation of CFC hours. The hearing record was extended until [redacted] [redacted], 2018. No further communication from the Department was received. (Hearing Officer Ex. AA: Emails to Hearing Officer)

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. 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 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. 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, supervision, and/or cueing.

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.

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 I 902(a)(IO)(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. Based on the Department's hearing summary, exhibits, and testimony it is unclear if the Department's reduction of hours is in accordance with federal and state regulations.

DISCUSSION

The Department failed during the administrative hearing to adequately explain its rationale in the calculation of the Appellant's CFC hours. The Department recognized during the administrative hearing that it has made errors in the calculation of the Appellant's services under the CFC program. The Department

was given additional time after the administrative hearing to address those errors and to evaluate the Appellant's additional documentation but has failed to do so as of the writing of this decision.

DECISION

The Appellant's appeal is **REMANDED TO THE DEPARTMENT** for further action

ORDER

1. The Department will review the Appellant's submitted additional medical information and the budget and number of hours allocated from DDS.

2. The Department will recalculate the Appellant's budget and number of hours allowed under the Connecticut State Plan and Code of Federal Regulations for CFC services.

3. Once the Department makes a decision regarding budget and CFC hours for the Appellant, a new notice shall be issued to the Appellant *and the Appellant's **Legal Guardian*** with a detailed explanation of the calculation.

4. Compliance with this order should be forwarded to the undersigned no later than ████████, 2018.

Marci Ostroski
Hearing Officer

CC: Christin Weston, DSS – Central Office
Dawn Lambert, DSS – Central Office
Lisa Bonetti, DSS – Central Office
Sallie Kolreg, 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.