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

[redacted] **2019**
Signature Confirmation

Case # [redacted]
Client 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 to [redacted] (the "Appellant") denying his request for Personal Care Attendant services through the Community First Choice ("CFC") program due to not meeting the institutional level of care criteria.

On [redacted] 2018, the Appellant requested an administrative hearing to contest the Department's denial of his application for CFC services.

On [redacted] 2019, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2019 at the Appellant's home.

On [redacted] 2019, in accordance with sections 17b-60, 17b-61, and 4-176e to 4-184, inclusive, of the Connecticut General Statutes, OLCRAH held an administrative hearing at the Appellant's home.

The following individuals were present at the hearing:

[redacted]
Bonnie Sutherland, CFC Supervisor, Western Connecticut Area Agency on Aging
Katelyn Palermo, CFC Assessor, Western Connecticut Area Agency on Aging
Christine Weston, CFC Representative, DSS Central Office
Christopher Turner, Hearing Officer

The Appellant was not present due to his DDS day program attendance.

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department correctly denied the Appellant's CFC application for Personal Care Attendant ("PCA") services due to unmet activities of daily living.

FINDINGS OF FACT

1. The Appellant is a recipient of a DDS Medicaid waiver and receives services from the Department of Developmental Services ("DDS") through his participation in DDS' day program. (Hearing summary; Record, Parent's testimony)

2. DDS acts as a Medicaid operating partner under a Memo of Understanding with the Department. (Department's testimony; Hearing summary)

3. [redacted] 2018, the Department issued a notice to the appellant denying his request for CFC services because he does not meet the institutional level of care criteria. (Notice dated [redacted]18)

4. The Appellant is [redacted]. (Record; Parent's testimony)

5. The Appellant has been diagnosed with pervasive developmental disorder not otherwise specified, intellectual disability, and seasonal allergies. (Exhibit 3: DDS Assessment; Hearing summary)

6. The Appellant does not have any prescribed treatments or care such as catheters, needle injections, nebulizers, oxygen, respiratory suctioning, postural drainage, ostomy, tracheostomy, tube feeding, or artificial ventilator. (Exhibit 3)

7. The Appellant does not require hands on or direct care from a nurse. (Exhibit 3; Parent's testimony)

8. The Appellant's parents are his primary and secondary caregivers who provide unpaid voluntary assistance. (Exhibit 3; Record; Hearing summary)

9. [redacted] 2018, the Appellant participated in a comprehensive Level of Need assessment ("LON") with DDS for a review of Medicaid long-term care supports and services. The assessment included an evaluation of the Appellant's physical status, mental status, and functional abilities, a more detailed consideration of the Appellant's Activities of Daily Living ("ADLs"), Instrumental Activities of Daily Living ("IADL's"), and health related tasks at home and day program. The assessment recorded the Appellant concerning support needed and support level required. The scoring ranged from zero to eight with zero being no assistance/issues with eight needing elevated or pronounced assistance and scored support level required from zero to four with zero indicating no support and four more than one person required. (Exhibit 3; Hearing summary)

10. The Appellant scored a two on his LON regarding disruptive behaviors, not aggression at home and day program with a support level of six at home and day program. (Exhibit 3)

11. The Appellant scored a three on his LON regarding mild physical assault or aggression issues at home and day program with a support level of six at home and day program. (Exhibit 3)

12. The Appellant scored a four on his LON concerning severe physical assault or aggression at home and day program with a support level of six at home and day program. (Exhibit 3)

13. The Appellant scored a four on his LON concerning property destruction aggression at home and day program with a support level of six at home and day program. (Exhibit 3)

14. The Appellant scored a three on his LON concerning self-injurious behavior at home and day program with a support level of six at home and day program. (Exhibit 3)

15. The Appellant scored a two on his LON concerning sexually inappropriate behavior at home and day program with support level of six at home and day program. (Exhibit 3)

16. The Appellant scored a four on his LON regarding a history of physical assault at home and day program with a support level of six at home and day program. (Exhibit 3)

17. The Appellant is not considered a risk for eating or drinking nonfood items (Pica) at home or day program. (Exhibit 3)

18. The Appellant is not considered a risk for bolting or wandering away at home or day program. (Exhibit 3)

19. The Appellant is not considered a risk for criminal concerns, within the past year, at home or day program. (Exhibit 3)

20. The Appellant is not on parole or probation. (Exhibit 3)

21. The Appellant does not have a history of sexual assault or sexual aggression towards others. (Exhibit 3)

22. The Appellant is not on the sex offender registry. (Exhibit 3)

23. The Appellant does not have a diagnosed psychotic or psychiatric disorder or other mental health condition. (Exhibit 3)

24. The Appellant requires assistance with the following IADL's: prompting with taking medications, completing household chores, shopping and meal preparation. (Exhibit 3)

25. The Appellant needs prompting with basic home safety issues such as fire alarm, no heat, or power outage. (Exhibit 3)

26. The Appellant's home is accessible to meet his needs, including bathing facilities. (Exhibit 3)

27. The Appellant is not at risk for homelessness. (Exhibit 3)

28. The Appellant takes the following medications: Trazodone, Ranitidine, Trokendi, and Haloperidol. The Appellant also wears a Daytrana patch for behavioral issues. (Parent's testimony)

29. The Appellant requires a harness with an aide present when being transported by motor vehicle. (Exhibit 3; Parent's testimony)

30. The Appellant visits the doctor's office 12-23 times a year and has had two behavioral episodes at home resulting in the Appellant's family calling 911. (Exhibit 3)

31. Western Connecticut Area Agency on Aging ("WCAAA") is the Department's contractor for assessing level of care and service needs for CFC services. (Record; Hearing summary)

32. [redacted] WCAAA conducted a universal assessment with the Appellant. Given that DDS had completed a comprehensive assessment within the prior 12 months, the reassessment included a review of the DDS assessment and a more detailed analysis of the Appellant's core ADL's. The universal assessment found the Appellant is independent with transferring but requires supervision with bathing and toileting as well as limited assistance with dressing. The Appellant was found to be independent with eating and transferring. (Exhibit 2: Universal assessment; Hearing summary)

33. The Appellant leaves home between 8:30 and 9:00 A.M. to attend his DDS weekday group day support program at [redacted] and returns home around 4:00 P.M. (Exhibit 3; Parent's testimony)

34. The Appellant's mother works weekdays from 7:30 am to 3:30 pm, five days a week. (Parent's testimony)

35. The Appellant's father is home from 2:30 P.M. onward. The Appellant's father is not present in the morning. (Parent's testimony)

36. The Appellant's father has a bad back and experiences difficulty controlling [redacted] at times when [redacted] acts out two to three times per week. (Father's testimony)

37. The Appellant cannot be left home alone for any length of time during the day or night. (Exhibit 3; Parent's testimony)

38. The Appellant's parents are home during evening hours and on weekends. (Exhibit 3; Parent's testimony)

39. The Appellant's mother has found it increasingly difficult to get [redacted] ready for his DDS program. At times, the Appellant's mother is late for work two to three times per weekday because of [redacted] reluctance to shower or get dressed. (Parent testimony)

40. The Appellant's parents are requesting support services for [redacted] on weekday mornings and afternoons for a total of 5-6 hours daily. (Record; Parent's testimony)

41. There is insufficient evidence in the hearing record to ascertain whether PCA services our necessary for the Appellant to address unmet activities of daily living. (Record)

CONCLUSIONS OF LAW

1. Connecticut General Statutes § 17b-2 provides that the Department of Social Services is designated as the state agency for the administration of (6) the Medicaid program pursuant to Title XIX of the Social Security Act.

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

3. Title 42 of the CFR § 441.505 defines activities of daily living ("ADL'S") means basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

4. Title 42 of the CFR § 441.505 defines instrumental activities of daily living ("IADL'S") 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 of the CFR § 441.510 addresses 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: (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 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.

   42 U.S.C. 1396n(C)(1) provides in part that by way of a Medicaid waiver the State plan may provide for all or part of community based services for individuals that would require ICF level of care for the mentally retarded.

   The Department incorrectly determined that the Appellant does not meet the institutionalized Level of Care because, since he is on a DDS Medicaid waiver, he therefore meets the institutionalized Level of Care.

6. Title 42 of the CFR § 441.520 provides for included services. (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. (b) At the State's option, the State may provide permissible services and supports that are linked to an assessed need or goal in the individual's person-centered service plan. Permissible services and supports may include, but are not limited to, the following: (1) Expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities linked to an assessed need for an individual to transition from a nursing facility, institution for mental diseases, or intermediate care facility for Individuals with Intellectual Disabilities to a home and community-based setting where the individual resides. (2) Expenditures relating to a need identified in an individual's person-centered service plan that increases an individual's independence or substitutes for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

Title 42 of the 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 was correct when it conducted an annual reassessment of the Appellant's needs.

The Department was correct when it determined that the Appellant requires supervision and cueing with all of his ADLs except eating, and transferring.

The Department was correct when it determined that the Appellant requires assistance and or cueing with all of his IADLs except mobility in the community.

7. Connecticut General Statutes §17b-259b defines medically necessary and medical necessity. (a) provides 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.

   Connecticut State Plan Amendment no.15-012 (5)(A), pursuant to section 1915(k) of the Social Security Act, provides for limits on amount, duration or scope of included services. It states that the Department assigns an overall budget based on need grouping that is determined by algorithm and that natural supports are based on the individual’s functional assessment, which will take into consideration the availability of natural supports. Natural supports are identified during the person-centered service planning process and utilized when available to the individual. Natural supports are defined as voluntary unpaid care provided on a regular and consistent basis by a parent, spouse, or other person.

   The Department correctly determined that the Appellant’s parents are a source of natural support for his ADL’s and IADL’s.

   Based on the evidence provided, the denial of the Appellant’s application for PCA services through CFC is upheld. The Department correctly determined PCA services are not medically necessary for the Appellant to meet his functional needs because the type, frequency, and duration of such services are not clinically appropriate at this time given that other services and natural supports are currently in place.

DISCUSSION

While the department's notice reflects a denial based on the Appellant not meeting level of care, wherein he does by virtue of being on a DDS Medicaid waiver, I find that the evidence presented does not support the need for a PCA in the morning before the appellant attends his day program or in the afternoon when he arrives home. There is not an adequate amount of evidence in the hearing record or compelling testimony offered to support that this need exists.

DECISION

The Appellant's appeal is denied.

Christopher Turner
Hearing Officer

Cc: Sallie Kolreg, Department of Social Services, Central Office
Dawn Lambert, Department of Social Services, Central Office
Christine Weston, Department of Social Services, 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. 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.