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

[redacted] **2022**
SIGNATURE CONFIRMATION

CASE # [redacted]
CLIENT# [redacted]
REQUEST# [redacted]

NOTICE OF DECISION
PARTY

[redacted]

PROCEDURAL BACKROUND

On [redacted] 2022, the Department of Social Services (the "Department") and Community First Choice ("CFC") sent [redacted] (the "Appellant"), a Notice of Action ("NOA") denying his participation in the CFC program because he does not meet the level of care criteria necessary to be eligible for the CFC Individual Budget program.

On [redacted], 2022, the Appellant requested an administrative hearing to contest the denial of his participation in the CFC program due to not meeting the level of care criteria.

On [redacted] 2022, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2022.

On [redacted] 2022, in accordance with sections 17b-60, 17b-61 and 4-176e to 4-189 inclusive, of the Connecticut General Statutes, OLCRAH held a telephonic administrative hearing. The following individuals participated in the hearing:

Appellant, [redacted]
Appellant's Mother/Authorized Representative ("AREP"), [redacted]
[redacted] Supervisor, Myra Davis
Hearing Officer, Joshua Couillard

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department correctly denied the Appellant participation in the CFC program due to not meeting the level of care criteria.

FINDINGS OF FACT

1. The Appellant is 32-years-old [DOB: [redacted] 1989] and has Husky C Aid to the Aged, Blind and Disabled ("AABD") Medicaid benefits. (Appellant's Testimony)

2. The Appellant lives at home with his mother. (AREP's Testimony)

3. The Appellant's AREP will be returning to work and will be unable to provide daily needs support for the Appellant. (AREP's Testimony)

4. The CFC program is designed to provide consumers with services to meet their Activities for Daily Living ("ADL") needs. If consumers meet the level of care criteria, the program allows them to hire a Personal Care Assistant ("PCA") to assist them with their daily care to prevent them from being institutionalized. (Agency on Aging's Testimony)

5. On [redacted] 2022, a Specialized Care Manager from the [redacted] completed a face-to-face Universal Assessment Outcome form for the Appellant. (Exhibit 1: Universal Assessment Outcome Form, Hearing Record)

6. The Specialized Care Manager's Level of Care Assessment found the Appellant's ADL support needs as follows: The Appellant requires cueing or supervision with bathing. The Appellant is independent with dressing, toileting, transferring and eating. (Exhibit 2: Level of Care Assessment Form, Exhibit 1, Hearing Record)

7. The Specialized Care Manager's Level of Care Assessment found the Appellant's Instrumental Activities of Daily Living ("IADL") support needs as follows: The Appellant requires total dependence with meal preparation, managing finances and shopping. The Appellant requires maximal assistance with ordinary housework. The Appellant requires cueing or supervision with managing medications. The Appellant is independent with transportation. (Exhibit 2)

8. The Appellant's primary diagnosis is bipolar disorder and developmental delay. (Exhibit 1)

9. The Appellant is not receiving any physical, occupational or speech therapy. (AREP's Testimony)

10. On [redacted] 2022, the Department issued a NOA to the Appellant denying his participation in the CFC program as the Appellant does not meet the institutional level of care requirement. (Exhibit A: Notice of Action)

11. The issuance of this decision is timely under Connecticut General Statutes 17b-61(a), which requires that a decision be issued within 90 days of the request for an administrative hearing. The hearing request was received on [redacted] 2022; therefore, this decision is due no later than [redacted] 2022.

CONCLUSIONS OF LAW

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

2. "*Basis and Scope*. 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. Community First Choice is designed 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." 42 Code of Federal Regulations ("C.F.R.") § 441.500

3. "*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." 42 C.F.R. § 441.535

The Department correctly completed a face-to-face Universal Assessment of the Appellant's needs on [redacted] 2022.

4. "*Definitions*. 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." 42 C.F.R. § 441.505

   The Department correctly found that the Appellant requires cueing or supervision with bathing, and is independent with dressing, toileting, transferring and eating.

5. "*Definitions*. 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. 42 C.F.R. § 441.505

   The Department correctly found that the Appellant requires total dependence with meal preparation, managing finances, and shopping; requires maximal assistance with ordinary housework; requires cueing or supervision with managing medications, and is independent with transportation.

6. "*Eligibility*. 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." 42 C.F.R. § 441.510

7. "*Waiver Respecting Medical Assistance Requirement in State Plan.* A waiver granted under this subsection may… provide medical assistance to individuals (to the extent consistent with written plans of care, which are subject to the approval of the State) for case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness." Title 42 of the United States Code § 1396n(c)(4)(B)

The Department correctly determined, based upon the Universal Assessment, that the Appellant is not at risk of being institutionalized without the home and community-based services.

8. "*'Medically Necessary' and 'Medical Necessity' defined.* (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." Conn. Gen. Stat. § 17b-259b(a) & (b)

The Department correctly determined, based upon the Universal Assessment completed on [redacted], 2022, that the Appellant does not meet the institutional level of care criteria that is necessary to qualify for CFC services.

The Department correctly determined that PCA services through CFC are not medically necessary for the Appellant.

DECISION

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

Joshua Couillard

Joshua Couillard
Fair Hearing Officer

CC: hearings.commops@ct.gov
Karri Filek, 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 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, 165 Capitol Avenue, 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.