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

[redacted] **2023**
Signature Confirmation

Case # [redacted]
Client # [redacted]
Request # 207239

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2022, the Department of Social Services (the "Department") issued a Notice of Action ("NOA") to [redacted] (the "Appellant") entitled, "Denial of Participation in Community First Choice Program" denying her request for increased Personal Care Attendants ("PCA") service hours under the Community First Choice ("CFC") program.

On [redacted] 2022, the Department issued a second NOA to the Appellant entitled, "Denial of Request to Increase Services" again denying her request for increased PCA service hours under the CFC program.

On [redacted] 2022, the Appellant requested an administrative hearing to contest the denial of increased PCA hours under the CFC program.

On [redacted] 2022, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2023, in person.

On [redacted] 2023, the Appellant was in attendance, but the Department did not attend the scheduled administrative hearing. The Appellant requested for the administrative hearing to be rescheduled by telephone.

On [redacted] 2023, the OLCRAH issued a notice rescheduling the administrative hearing for [redacted] 2023, by telephonic conferencing.

On [redacted] 2023, the Appellant contacted the OLCRAH and requested for the administrative hearing to be held in person at her residential address.

On [redacted] 2023, the OLCRAH issued a notice rescheduling the administrative for [redacted] 2023, in person at the Appellant's residential address.

On [redacted] 2023, the OLCRAH issued a notice updating the assigned Hearing Officer.

On [redacted] 2023, 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 in person at the Appellant's residence of [redacted].

The following individuals participated in person at the hearing:

[redacted], Appellant
[redacted], Appellant's mother / conservator
[redacted], Appellant's PCA
[redacted], Appellant's brother
Pia Pyles, Department's Attorney
Jose Gonzalez, Department's Money Follows the Person ("MFP") Program Manager
Deborah Fox, Department's Community Nurse, Registered Nurse ("RN")
Orenthia Channe, Department's Community Nurse, RN
[redacted], Agency on Aging [redacted], Director of Transitional Programs
Jessica Gulianello, Hearing Officer

The Hearing Record remained open until [redacted] 2023, for the submission of additional documentation from the Appellant and the Department. Additional information was received from both parties and on [redacted] 2023, the hearing record closed accordingly.

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department correctly denied the Appellant's request for additional PCA hours under the Husky Medical CFC program.

FINDINGS OF FACT

1. The Appellant is [redacted] ([redacted]) years old (DOB: [redacted]). *(Hearing Record)*

2. The Appellant resides in the community with [redacted]. *(Hearing Record)*

3. The Appellant is a Medicaid recipient. *(Hearing Record)*

4. In 2021, the Appellant was determined eligible for services under the CFC with an annual budget of $110,093.76 equivalent to 105 hours of PCA services per week. *(Exhibit 4: Community First Choice Plan, 2021)*

5. The Agency on Aging [redacted] ("AOASC") is an [redacted] access agency contracted by the Department that meets the qualifications as defined in Connecticut's State Plan to assess an individual's level of care ("LOC") and service needs as well as assist the individual in receiving home and community-based services. *(Hearing Summary, Department's Testimony)*

6. On [redacted], 2022, the Appellant participated in a face-to-face annual comprehensive reassessment known as the Universal Assessment ("UA") conducted by a social worker from AOASC to determine the Appellant's level of need ("LON") based on information pertaining to the following: core Activities of Daily Living ("ADLs"), Instrumental Activities of Daily Living ("IADLs"), health-related tasks, primary caregivers (paid and unpaid), living situation, transportation needs, and behavioral needs. *(Exhibit 5B: UA – [redacted]/2022, Hearing Summary, Department's Testimony)*

7. The Appellant's medical diagnoses include but are not limited to: [redacted]. *(Exhibit 5B: UA – [redacted]/2022, Hearing Summary, Department's Testimony)*

8. The Appellant has been prescribed the following medications: [redacted]. *(Exhibit 5B: UA – [redacted]/2022)*

9. The Appellant's core ADL needs were determined to be as follows:

Core ADL	Need:
Bathing	Total Dependence

Dressing	Total Dependence
Toileting	Max Assistance
Transferring	Total Dependence
Eating	Total Dependence

(Exhibit 5B: UA – [redacted]/2022, Hearing Summary, Department's Testimony)

10. The Appellant's IADL needs include assistance with the following: taking medication, using the telephone, performing household chores, budgeting, meal preparation, and shopping. *(Exhibit 5B: UA – [redacted]/2022, Hearing Summary, Department's Testimony)*

11. The Appellant receives informal support from her family. The Appellant's primary caregiver is [redacted]. *(Exhibit 5B: UA – [redacted]/2022, Hearing Record)*

12. The Appellant expressed an increase in [redacted] during the UA. The Appellant reported that she requires assistance throughout the [redacted] and frequent manual adjustments. The Appellant reported that her [redacted] currently holds the primary responsibility as her [redacted] caregiver, and they are both often left [redacted]. The Appellant requested additional PCA hours to provide her with [redacted] hands-on support to develop a better [redacted] routine. *(Exhibit A: Appellant's Hearing Request)*

13. The Appellant's core ADL needs and the information obtained through the UA were used to determine her level of need, budget under CFC, and the appropriate number of PCA support hours. *(Hearing Summary, Department's Testimony)*

14. The Department's clinical nurse, community nurse coordinator, and Medicaid Medical Director each reviewed the UA, including the detailed assessment of the Appellant's core ADLs, and they determined there to be no change in the Appellant's condition to warrant an increase in funding under the CFC. The Department determined 105 hours of PCA support services per week remained appropriate to meet the Appellant's needs. *(Hearing Summary, Department's Testimony)*

15. AOASC orally informed the Appellant of the Department's denial of her request for additional PCA hours under CFC. *(AOASCC Testimony)*

16. On [redacted] 2022, the Appellant and [redacted], participated in a [redacted] meeting at the request of AOASC. *(Exhibit A: Appellant's Hearing Request)*

17. The Appellant followed up with the respective parties and was advised that they were awaiting medical records. *(Exhibit A: Appellant's Hearing Request)*

18. On [redacted] 2022, the Department received a letter dated [redacted], 2022, from [redacted] MD Ph.D., Attending [redacted] at [redacted] Hospital [redacted] by email from the Appellant. The letter states the following:

> [redacted] *She has requested increase care hours to handle the* [redacted] *changes and overall progression. I feel these are justified."*

(Exhibit B: Medical Documentation: Letter dated [redacted] */2022)*

19. On [redacted] 2022, the Department received a letter dated [redacted] 2022, from [redacted], PsyD of [redacted] Medicine, [redacted] by email from the Appellant. The letter states the following:

> [redacted] *I am in agreement that this would be extremely helpful and would be happy to answer any other questions anyone may have."*

(Exhibit B: Medical Documentation: Letter dated [redacted] */2022)*

20. On [redacted] 2022, the Department received a letter dated [redacted] 2022, from [redacted], PA of [redacted] Medicine, [redacted] by email from the Appellant. The letter states the following:

> [redacted]

[redacted] *Unfortunately these symptoms are becoming a bit more frequent and she is requiring more care. Any additional services or support to* [redacted] *and her* [redacted] *that can be offered would be greatly appreciated and very much appropriate for them."*

(Exhibit B: Medical Documentation: Letter dated [redacted] *2022)*

21. On [redacted] 2022, the Department issued the Appellant an NOA entitled, "CFC Program Service Budget Reduction". The NOA stated, "The Department previously authorized a CFC Individual Budget for you of $120,279.60. Your New Budget: Today, we reassessed your LON and our reviewed CFC Individual Budget is $120,279.60. This budget amount is equal to about 105 hours of Personal Care Assistance (PCA) per week." The NOA also stated, "Other: You requested an increase in PCA hours, but after formal review by Central office your request for more hours will not be granted" *(Exhibit A: NOA,* [redacted] *2022)*

22. On [redacted] 2022, the Department issued the Appellant a NOA entitled, "Denial of Participation in CFC Program". The NOA stated, "The Department has reviewed your proposed service plan for CFC, and determined that you are not eligible for CFC because: Other: Denial of request for increased PCA hours after formal review, did not meet the criteria for medical necessity; Conn. Gen. Stat. Section 17b-259b". *(Exhibit A: NOA,* [redacted] *2022)*

23. On [redacted] 2022, the Department issued the Appellant a NOA entitled, "Denial for Request to Increase Services". The NOA stated, "The Department has reviewed your proposed service plan for increased services, and determined that you are not eligible: Other: Denial of request for increased PCA hours after formal review, did not meet the criteria for medical necessity; Conn. General State. Section 17b-259b". *(Exhibit A: NOA,* [redacted] */2022)*

24. On [redacted] 2022, the OLCRAH received the Appellant's request for an administrative hearing to contest the Department's denial of additional PCA hours under the CFC program. *(Exhibit 1: Hearing Request,* [redacted] */2022)*

25. The Appellant provided the Department with documentation (three letters as previously noted) from her medical providers to support her diagnoses, the increased level of care that she requires, as well as her request for additional PCA hours under CFC based on medical necessity following the completion of the UA and before the Department issued the previously noted NOA's. *(Hearing Record)*

26. The Department subsequently conducted a third-party clinical review of the Appellant's case including a review of the aforementioned letters from the Appellant's medical providers. *(Department's Testimony)*

27. On [redacted] 2023, the Department notified the OLCRAH and the Appellant of their decision to reverse the denial of the Appellant's request for additional PCA hours. *(Exhibit 9: Departmental Email – [redacted]2023, Department's Testimony)*

28. On [redacted] 2023, the OLCRAH held an administrative hearing at the Appellant's request. The hearing record remained open until [redacted] 2023, for the submission of additional information from both parties. *(Hearing Record)*

29. On [redacted] 2023, the Department testified to its decision to reverse the previous denial and approve the Appellant's request for an additional 21 hours per week of PCA services under the CFC based on medical necessity. *(Department's Testimony)*

30. The Appellant does not dispute the new CFC budget as proposed by the Department. *(Appellant's Testimony)*

31. On [redacted] 2023, the Department issued the Appellant a Letter of Resolution. The letter states the following, "The Department as of [redacted]2023 has granted your request for an increase in PCA services to 126 hours per week. AOASC will be meeting with you to complete a new revised plan of care to reflect this change as soon as possible." *(Exhibit 7: Letter of Resolution,[redacted]/2023)*

32. On [redacted] 2023, AOASCC completed a revised CFC Individual Budget with the Appellant. The revised amount of $171,122.11 annually is equivalent to PCA services of [redacted]126 per week with a plan effective date of [redacted] 2023. *(Exhibit 8: Revised CFC Budget, signed [redacted]20223)*

33. On [redacted] 2023, the Department reviewed and approved the proposed budget of $171,122.11 annually citing the following justification, "The Department as of [redacted]2023 granted the request to increase hours from 105 to 126 hours per week. Per the department clinical review of the assessment hours were granted and met medical necessity. The additional 21 hours were granted by department under the state medical necessity statue. *(Exhibit 8: Budget Exemption Form, signed [redacted]/2023)*

34. The Hearing Record is void of a signed Letter of Resolution. *(Hearing Record)*

35. On [redacted] 2023, the hearing record closed accordingly. *(Hearing Record)*

36. 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 Appellant requested an administrative hearing on [redacted]. Therefore, this decision was not due until [redacted], 2023. The hearing, however, which was originally scheduled for [redacted], 2023, was rescheduled to [redacted] 2023, at the Department's request. The hearing that was rescheduled to [redacted] 2023, was subsequently rescheduled to [redacted] 2023, at the Appellant's request which caused a [redacted]-day delay. Because this [redacted]day

delay resulted from the Appellant's request, this decision was not due until [redacted] 2023. However, the hearing record, which had been anticipated to close on [redacted], 2023, did not close for the admission of evidence until [redacted] 2023, resulting in an additional [redacted]-day delay. This final decision is not due until [redacted] 2023, and is therefore timely. *(Hearing Record)*

CONCLUSIONS OF LAW

1. Section 17b-2 of the Connecticut General Statutes ("Conn. Gen. Stat.") authorizes the Commissioner of the Department of Social Services to administer the Medicaid program.

2. Title 42 of the Code of Federal Regulations ("C.F.R.") 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.

3. Title 42 C.F.R. § 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. Title 42 C.F.R. § 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. Title 42 C.F.R. § 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 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. Title 42 C.F.R. § 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.

7. Title 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 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. Title 42 CFR § 441.540(b)(5) provides that the person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under Community First Choice, the plan must reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports cannot supplant needed paid services unless the natural supports are unpaid supports that are provided voluntarily to the individual in lieu of an attendant.

9. Connecticut State Plan Amendment ("SPA") 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.

10. Connecticut General Statutes § 17b-259b(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.

11. Uniform Policy Manual ("UPM") § 1570.25 (c)(2)(k) provides that the Fair Hearing Official renders a Fair Hearing decision in the name of the Department, in accordance with the Department's policies and regulations. The Fair Hearing decision is intended to resolve the dispute.

12. UPM § 1570.25(F)(1) provides that the Department must consider several types of issues at an administrative hearing, including the following:

    a. eligibility for benefits in both initial and subsequent determinations.

    The Department has approved the Appellant's request for additional PCA hours under the CFC. Thus, the Appellant's request for a hearing has been resolved.

13. The Appellant's hearing issue has been resolved, therefore, there is no issue on which to rule. "When the actions of the parties themselves cause a settling of their differences, a case becomes moot." McDonnell v. Maher, 3 Conn. App. 336

(Conn. App. 1985), citing, Heitmuller v. Stokes, 256 U.S. 359, 362-3, 41 S.Ct. 522, 523-24, 65 L.Ed. 990 (1921).

The service which the Appellant had originally requested has been approved; there is no practical relief that can be afforded through an administrative hearing.

DISCUSSION

Community First Choice is a benefit available to Medicaid recipients under the State Plan to provide services in-home to individuals who would otherwise require institutionalization as determined by state standards. The AOASC correctly conducted an in-person annual UA on behalf of the Department to determine the Appellant's LON and calculate a corresponding budget under CFC. Based on the testimony and evidence provided the Department incorrectly denied the Appellant's request for an increased budget to allocate additional PCA hours under CFC as not medically necessary. The Department subsequently re-evaluated the information that it had already received. Based on a third-party clinical review with a specific focus on the letter dated [redacted], 2022, from [redacted] MD Ph.D., the Department concluded that the Appellant is eligible for the proposed budget increase to $171,122.11 annually equivalent to 126 PCA hours per week pursuant to the medical necessity statute. The Appellant does not dispute the revised budget under CFC. The Appellant and her representatives requested to proceed with the hearing to respectfully express their frustration with the Department and the significance that the delay in the approval of the additional PCA hours under CFC has had on the family. While the Appellant's concerns are respectfully noted no practical relief can be afforded through an administrative hearing.

DECISION

The Appellant's appeal is **DISMISSED AS MOOT.**

Jessica Gulianello

Jessica Gulianello
Hearing Officer

Cc: hearings.commops@ct.gov

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.