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

[redacted] 2024
Signature Confirmation

Client ID [redacted]
Case ID [redacted]
Request No. 236955

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2024, Connecticut Community Care, Inc. ("CCCI") on behalf of the Department of Social Services (the "Department") issued a Notice of Action to [redacted] (the "Appellant") reducing the number of Personal Care Attendants ("PCA") service hours under the Community First Choice ("CFC") program from forty-one and three quarter (41.75) hours per week to seventeen and one half (17.50) hours per week.

On [redacted] 2024, the Appellant requested an administrative hearing to contest the Department's decision to limit service hours under the PCA program to 17.50 hours per week.

On [redacted] 2024, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2024.

On [redacted] 2024, in accordance with sections 17b-60, 17b-61 and 4-176e to 4-189 inclusive of the Connecticut General Statutes, OLCRAH held an administrative hearing via teleconference at the Appellant's request.

The following individuals were present for the hearing:

[redacted] Appellant
[redacted] Case Manager, [redacted]
[redacted] Clinical Operations Manager, [redacted]

[redacted] Community Support Clinician, [redacted]
[redacted] Intensive Care Manager, [redacted]
Janette Steward, Nurse Consultant, Department of Social Services
Eric Bulewich, Social Worker, Department of Social Services
Cynthia Cartier, Staff Counsel, Department of Social Services
Lisa Nyren, Fair Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department's decision to limit PCA service hours under the Community First Choice ("CFC") program to 17.5 hours per week for the Appellant beginning [redacted] 2024 was correct.

FINDINGS OF FACT

1. The Appellant is a recipient of Medicaid under the Husky C program as administered by the Department. (Hearing Record)

2. The Appellant receives Personal Care Attendant ("PCA") services as administered under the Community First Choice ("CFC") program. (Hearing Record)

3. The CFC program helps Medicaid recipients remain in the community and avoid nursing facility placement. Under the CFC program, applicants are assessed using the Universal Assessment tool ("UA") (developed by the University of Connecticut) to determine the appropriate level of need and CFC budget based on the applicant's need for assistance with Activities of Daily Living ("ADL's"), Instrumental Activities of Daily Living ("IADL's"), and health-related tasks. The CFC program primarily looks at hands on care needed for bathing, dressing, toileting, eating, and transferring. (Department Social Worker Testimony, Exhibit 4: State Plan Amendment, and Exhibit 5: Operating Manual)

4. The Appellant receives services under the Mental Health Waiver program also known as WISE (**W**orking for **I**ntegration, **S**upport and **E**mpowerment) as administered by the Department of Mental Health and Addiction Services ("DMHAS"). The WISE program provides an array of rehabilitation and support services to allow a recipient to remain in the community and avoid institutional care. (Hearing Record)

5. The WISE program is a skill building program to support recipients through prompting and assistance, but it is not meant to be a chore service. Because the WISE program does not cover those services related to Activities of Daily Living ("ADL's), recipients enrolled in WISE

who need such supports can choose to access ADL supports through the CFC program, specifically PCA services. Additionally, WISE recipients who access CFC do not qualify for Instrumental Activities of Daily Living ("IADL's) under the CFC program because those needs are addressed under the WISE program. (Intensive Care Manager Testimony)

6. The Appellant is [redacted] years old. (Appellant Testimony)

7. The Appellant lives at home with her adult son [redacted] age [redacted] (Appellant's Testimony)

8. The Appellant's medical diagnosis includes neuropathy, hypertension, post-traumatic stress disorder, anxiety, fibromyalgia, epilepsy, and dermatomyositis. Dermatomyositis is a rare autoimmune disease which attacks the skin and muscles resulting in painful and itchy skin rash and muscle weakness. (Appellant Testimony and Exhibit 1: Annual Reassessment)

9. The Appellant was a victim of spousal abuse for which she endured years of trauma before leaving the abusive [redacted] year marriage during the pandemic. The trauma caused from the abusive relationship has had a profound impact on the Appellant's physical, emotional, and financial health. (Appellant's Testimony)

10. The Appellant requires assistance with ADLs which include dressing and transfers. The Appellant requires assistance with zippers and buttons when dressing which takes about 20 minutes daily. The Appellant gets dizzy and weak and is unable to stand for any length of time. The Appellant is at risk of falling. The Appellant uses a walker and cane. The Appellant requires some assistance with bathing such as prompting to bathe or wash her hair. Due to muscle weakness, safety is a concern while showing, therefore the Appellant uses a shower bench. The Appellant is independent when toileting and eating. (Appellant's Testimony)

11. The Appellant employs the adult son as her PCA. The adult son is not employed elsewhere. The adult son performs numerous housekeeping chores for the Appellant which include laundry, dishes, vacuuming, cooking, and making the bed. The adult son assists the Appellant when dressing, bathing, and with mobility. The adult son assists the Appellant with her exercises. The adult son monitors the Appellant's medication and daily schedule which may include medical appointments. The adult son provides transportation to and from medical appointments. (Appellant's Testimony)

12. The adult son did not participate in the administrative hearing. (Hearing Record)

13. In [redacted] 2024, CCCI completed the annual reassessment of the Appellant's benefits under the PCA program using the UA. The assessment included observation and contact with the Appellant and the adult son over a three-day period. CCCI determined the Appellant's Level of Need under the CFC program as One (1) on the Level of Need scale from One to Six, six being the highest need. CCCI noted the Appellant requires extensive assistance with dressing and transferring (2 ADL's), limited assistance with bathing, and independent with toileting and eating. CCCI listed the primary diagnoses which is impacting care as neuropathy, hypertension, PTSD, anxiety, fibromyalgia, and epilepsy. CCCI noted the Appellant as alert and orientated, requires no medication supports beyond set up, lives with adult son, and no behavioral concerns. (Case Manager Testimony and Exhibit 1: Annual Reassessment & CFC Individual Budget)

14. CCCI is the Department's contractor for completing annual assessments under the PCA program. (Department Social Worker Testimony)

15. Because the Appellant required extensive assistance with dressing and transferring (2 ADL's) and receives both CFC PCA services and DMHAS waiver services, the Appellant qualified for 17.50 PCA hours under CFC Budget category C: CFC combined with DHMAS waiver. The Appellant's budget equals $23,766.96. 17.50 hours/week x $26.32 CFC hourly pay rate x 4.3 weeks x 12 months = $23,766.96 annual budget. (Department Nurse Consultant Testimony and Exhibit 3: Budget Categories)

16. On [redacted] 2024, CCCI issued a Notice of Action Service Budget Reduction notice to the Appellant. The notice listed the CFC budget as $23,766.96 authorizing 17.50 hours per week under PCA services effective [redacted] 2024. (Exhibit 2: Notice of Action)

17. The CFC Unit completed a clinical review of the Appellant's service hours under the PCA program and determined the Appellant eligible for 17.50 hours per week under the PCA program to supplement her services under the WISE program. The CFC Unit then forwarded their budget decision to DMHAS so that DMHAS could complete the Person-Centered Recovery Plan with the Appellant and complete a consolidated cost sheet to ensure the Appellant's care plan remains under the WISE program cost limit. (Department Representative's Testimony and Intensive Care Manager Testimony)

18. Prior to the [redacted] 2024 reassessment, the Department authorized forty-one and one half (41.50) hours per week of PCA services. The Department was not aware the Appellant began receiving services under the WISE

program in [redacted] 2023. Approved DMHAS waiver care plans do not include funding for the ADL component of the budget, therefore the ADL component under CFC may be added to the waiver plan budget. (Department Representative Testimony and Exhibit 3: Budget Categories)

19. The Appellant's WISE Care Plan includes the following Mental Health Waiver services:

- Recovery Assistance through [redacted]. ("DMHAS provider") to aid in running errands, cleaning apartment, & cooking meals; 4 hours per day, 3 times per week;
- Community Support through the DMHAS provider to aid with medical and psychiatric follow-up, maintenance of social service paperwork & legal calendar; 2 hours per day, 1 time per week;
- Other, Community Support to assist Appellant with connecting with VNA services through PCP to order and administer medication;
- Personal Emergency Response System, [redacted]., for personal security & emergency contact when alone;
- PCA services provided by the adult child through CFC.

(Exhibit 6: WISE Care Plan and Exhibit 7: WISE Cost Share)

20. The Appellant is seeking to maintain 41.50 PCA service hours under the CFC program for which her adult son provides. (Appellant's Testimony)

21. 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] 2024. Therefore, this decision is due not later than [redacted] 2024.

CONCLUSIONS OF LAW

1. Connecticut General Statute ("Conn. Gen. Stats.") § 17b-2(6) provides as follows:

   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.

2. Title 42 of the Code of Federal Regulations ("CFR") § 441.500(a) provides as follows:

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. Federal regulation provides as follows:

   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 (ADL's), instrumental activities of daily living (IADLs), and health related tasks through hands-on assistance, supervision, or cueing. 42 CFR § 441.500(b)

   Federal regulation provides as follows:

   States must provide Community First Choice to individuals in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires to lead an independent life.

   42 CFR § 441.515(b)

   Federal regulation defines *Activities of Daily Living (ADLS)* as basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring. 42 CFR § 441.505

   Federal regulation defines *Instrumental Activities of Daily Living (IADLs)* as 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 CFR § 441.505

4. Federal regulation provides as follows:

   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 support 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 necessitation revisions to the person-centered service plan, and at the request of the individual.
d. Other requirements as determined by the Secretary.

42 CFR § 441.535

Connecticut State Plan Amendment ("SPA") Transmittal No 15-012 effective July 1, 2015 § 1(B) provides as follows:

The State determines initially, and at least annually, that individual require the level of care provided in a hospital, nursing facility, an intermediate care facility for individuals with intellectual disabilities (ICF/IID), an institution providing psychiatric services for individuals under 21, or an institution for mental diseases for individuals age 65 and older. The institutional level of care screen is completed by staff of the Department of Social Services on each individual referred to the program. Once an individual successfully completes the screen, the Department refers the individual to contracted entities for assessment. Staff at contracted entities completes the universal assessment for each individual. The universal assessment confirms institutional level of care and individual level of need.

SPA No 15-012 § 1(C) provides as follows:

The Universal Assessment (UA) is a comprehensive and person-centered assessment, surveying the –individual's physical, cognitive, and psychosocial functioning, and identifying risk factors, individual choices, and preferences, and the status of service needs. The UA identifies needs that are met utilizing voluntary natural supports, and state plan and waiver services, thus allowing for a comprehensive assessment, including need for social supports, and services plan. The UA documents each

individual's level of need and calculates that individual's budget allocation. Individuals are actively involved in the assessment process and have the opportunity to identify goals, strengths, and needs. Individuals affirm if they would like to identify anyone to participate in the planning process.

SPA No 15-012 § 7 provides in pertinent part as follows:

The UA is based on the InterRAI tool. The UA is a validation tool used to confirm level of care and calculate a level of need based on the identified needs of the Appellant. The UA assesses an Appellant's Activities of Daily living (ADLs) and Instrumental Activities of Daily Living (IADLs) needs as well as taking into account their health, rehabilitation needs, and their natural supports.

In [redacted] 2024, CCCI correctly completed a face-to-face assessment with the Appellant and the adult son under CFC using the UA over a three-day period identifying the individual's physical, cognitive, and psychosocial functioning, and identifying risk factors, individual choices and preferences, and the status of service needs.

5. State statute provides as follows:

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.

Conn. Gen. States. §17b-259b(a)

State statute provides as follows:

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. Stats. § 17b-259b(b)

6. Federal regulation provides as follows:

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.

42 CFR § 441.520(a)

SPA 15-012 § 1(A) provides in pertinent part as follows:

Individuals who are receiving 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 continue to meet all 19159c) 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.

Federal regulation defines *health-related tasks* as specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals under State law to be performed by an attendant. 42 CFR § 441.505

“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 CFR 441.510(e)

7. SPA 15-012 § 5(A) provides for Assistance with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) and health-related tasks through hands-on assistance, supervision, and/or cueing.

   Attendant Care: Services Definition: The State will cover Attendant Care services, which are supports related to core activities of daily living including; physical assistance and/or verbal assistance to the individual in accomplishing any Activities of Daily Living (ADLs), or Instrumental Activities of Daily Living (IADLs). ADLs may include, but not limited to, bathing, dressing, toileting, transferring, and feeding. 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 to participate in the community. In accordance with section 20-101 of the Connecticut General Statute, attendants may complete health maintenance tasks. These tasks may include, but are not limited to, medication administration, wound care, and vital signs under the supervision of the CFC Appellant.

   …

   Limits on amount, duration or scope: The Department assigns an overall budget based on need grouping that is determined by algorithm. 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.

8. Federal regulation provides as follows:

   For the self-directed model with a service budget, a service budget must be developed and approved by the State based on the assessment of functional need and person-centered service plan and must include all of the following requirements:

   1. The specific dollar amount an individual may use for Community First Choice services and supports.
   2. The procedures for informing an individual of the amount of the service budget before the person-centered service plan is finalized.

3. The procedures for how an individual may adjust the budget include the following:
    i. The procedures for an individual to freely adjust amounts allocated to specific services and supports within the approved service budget.
    ii. The circumstances, if any, that may require prior approval by the State before a budget adjustment is made.
4. The circumstances, if any, that may require a change in the person-centered service plan.
5. The procedures that govern the determination of transition costs and other permissible services and supports as defined at § 441.520(b).
6. The procedures for an individual to request a fair hearing under Subpart E of this title if an individual's request for a budget adjustment is denied or the amount of the budget is reduced.

42 CFR § 441.560(a)

Federal regulation provides as follows:

The budget methodology set forth by the State to determine an individual's services budget amount must:

1. Be objective and evidence-based utilizing valid, reliable cost data.
2. Be applied consistently to individuals.
3. Be included in the State plan.
4. Include a calculation of the expected cost of Community First Choice services and supports, if those services and supports are not self-directed.
5. Have a process in place that describes the following:
    i. Any limits the State places on Community First Choice services and supports, and the basis for the limits.
    ii. Any adjustments that are allowed and the basis for the adjustments.

42 CFR § 441.560(b)

The Department correctly determined the Appellant requires supports and supervision for a chronic condition requiring assistance daily.

Based on the CFC budget amounts as determined by the UA level of need, the Department correctly determined the Appellant's medical needs support the medical necessity for CFC for 17.50 hours per week. Although the adult son assists the Appellant with zippers and buttons when dressing, helps with transfers, and provides prompting to encourage proper hygiene/bathing, much of his assistance is

provided through housekeeping chores such as laundry, cooking, and cleaning. Under the WISE program the Appellant receives recovery assistant service twelve (12) hours per week to assist with running errands, cleaning the apartment, and cooking meals. She also receives 2 hours per week to help with medical and psychiatric follow-up, maintenance of social service paperwork and legal calendar. In addition, the Appellant receives assistance to connect with the VNA for medication administration.

Federal regulation allows that CFC recipients may receive additional services and supports through other Medicaid programs such as the WISE program, however, CFC recipients are not allowed to receive duplicative services from other available Medicaid sources. The WISE program provides services to support the Appellant's IADL needs therefore these services are not covered under the CFC as it would be duplication.

The hearing record does not reflect the need for additional PCA service hours above 17.50 hours under the CFC as requested by the Appellant. The Appellant's IADL needs are being met under the WISE program and should not be included in her PCA service hours under the CFC program. The Department's decision to limit PCA service hours under the CFC program is upheld.

9. "The State must have a procedure to adjust a budget when a reassessment indicates a change in an individual's medical condition, functional status, or living situation." 42 CFR § 441.560(f)

   "The State must have a method of notifying individuals of the amount of any limit that applies to an individual's Community First Choice services and supports. Notice must be communicated in an accessible format, communicated in plain language, and needed auxiliary aids and services should be provided." 42 CFR § 441.560(d)

   On [redacted] 2024, CCCI correctly issued a Revised CFC Individual Budget notice authorizing an annual budget of $23,766.96 equal to 17.50 hours per week under the CFC effective [redacted] 2024.

   On [redacted] 2024, CCCI correctly issued a Notice of Action Service Budget Reduction letter to the Appellant informing her that her CFC budget and service hours have been reduced allowing 21-days between the notice of action and effective date.

DECISION

The Appellant's appeal is denied.

Lisa A. Nyren
Lisa A. Nyren
Fair Hearing Officer

CC: Eric Bulewich, DSS
Cynthia Cartier, DSS
Janette Steward, DSS

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.