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

[redacted], 2024
SIGNATURE CONFIRMATION

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

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted], 2024, the Department of Social Services (the "Department") sent [redacted] (the "Appellant") a Notice of Action ("NOA") informing her of the reassessment of her Community First Choice ("CFC") Level of Need and Individual Budget reduction to $35,650.44 annually, with a decrease in her Personal Care Assistance ("PCA") hours to twenty-six and one quarter (26.25) hours per week effective [redacted], 2024.

On [redacted], 2024, the Appellant requested an administrative hearing to contest the reduction of her CFC weekly PCA hours.

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

On [redacted], 2024, in accordance with sections 17b-60, 17b-61, and 4-176e to 4-184, inclusive, of the Connecticut General Statutes, the OLCRAH held an administrative hearing. The following individuals participated in the hearing:

[redacted], Appellant
[redacted], Appellant's sister
Attorney Cynthia Cartier, JD, LLM, Staff Counsel, Department of Social Services
Janette Steward, RN, Nurse Consultant, Department of Social Services
Eric Bulewich, Social Worker, Community First Choice

Amy Santos, Manager, Connecticut Community Care
Joseph Davey, Administrative Hearing Officer

The hearing record remained open for the submission of information from the Appellant and CFC. Information was submitted by both parties and the record closed on [redacted], 2024.

STATEMENT OF THE ISSUE

The issue is whether the Department correctly reassessed and revised the Appellant's CFC PCA hours to twenty-six and one quarter (26.25) per week.

FINDINGS OF FACT

1. The Appellant is [redacted] years old (DOB [redacted]), a recipient of Medicaid, and lives alone in her home. (Appellant's testimony, Hearing Record)

2. The Appellant's medical diagnoses include the following: Bone Cancer, Neuropathy, Seizure Disorder, Fibromyalgia, a mental health issue, and Hematologic Malignancy. (Appellant's Exhibit A: Email from [redacted], MD dated [redacted], Exhibit 5: Universal Assessment Outcome Form dated [redacted], Appellant's testimony Hearing Record)

3. Connecticut Community Care ("CCC") is an organization contracted by the Department to conduct Universal Assessments ("UA") for the CFC program. A UA is a face-to-face[1] evaluation that identifies a person's Level of Need ("LON") by assessing a person's Instrumental Activities of Daily Living ("IADL's") using a scale between one and six points. IADL's include tasks such as homemaking, cueing, meal preparation, planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing household chores, communicating via telephone, and traveling within the community. The UA also assesses and provides a performance rating for a person's ability to complete Activities of Daily Living (ADL's) such as bathing, dressing, toileting, transferring, and eating. UA's are done yearly for the CFC program. (Hearing Record)

4. The CFC program uses the UA's LON score (i.e. IADL assessment) and ADL performance evaluation to determine the number of Personal Care Assistance ("PCA") hours a person qualifies for and to establish a budget to fund said PCA care. The budget methodology for funding the IADL and ADL components is *"determined using a standardized allocation chart."* (Exhibit 7: CFC Budget Categories)

5. An individual enrolled only in the CFC program utilizes the below-listed chart (Chart A1) which assigns PCA hours and the respective budget to fund them based on the UA LON score.

[1] UA's done during the COVID-19 pandemic were conducted via telephone.

Chart A1 – IADL Assessed Level of Need (LON) hour allocation			
LON	Hours of PCA per week	Monthly Budget	Annual Budget
1	13.00	$1,598.74	$19,184.88
2	17.00	$2,090.66	$25,087.92
3	21.50	$2,644.07	$31,728.84
4	23.50	$2,890.03	$34,680.36
5	25.75	$3,166.74	$38,000.82
6	28.75	$3,535.68	$42,428.10

(Exhibit 7, Hearing Record)

6. An individual enrolled only in the CFC program can add additional PCA hours and the respective budget to fund them, if the UA indicates they require *"Extensive or greater"* assistance performing any of the five ADL's of bathing, dressing, toileting, transferring, and eating. The below-listed chart (Chart A2) assigns the additional PCA hours and the respective budget to fund them based on the number of ADL's found to require *"extensive or greater"* assistance.

Chart A2 – ADL Extensive Hands-on for Activities of Daily Living (bathing, dressing, toileting, transferring, eating)			
ADLs	Hours of PCA per week	Monthly Budget	Annual Budget
1	8.75	$1,076.08	$12,912.90
2	17.50	$2,152.15	$25,825.80
3	26.25	$3,228.23	$38,738.70
4	35.00	$4,304.30	$51,651.60
5	43.75	$5,380.38	$64,564.50

(Exhibit 7, Hearing Record)

7. An individual enrolled in both the CFC program and a Department of Developmental Services ("DDS") / Department of Mental Health and Addiction Services ("DMAHS") waiver program may only receive PCA hours and the respective budget to fund them from the CFC program for their ADL needs. PCA hours and funding for the individual's IADL needs are financed through the DDS/DMHAS waiver and therefore cannot be duplicated by funding through the CFC program. As a result, a LON assessment and score is not given to individuals enrolled in CFC and a DDS/DMHAS waiver during the UA conducted for CFC services. (Exhibit 5, Exhibit 7, Mr. Bulewich's testimony)

8. An individual enrolled in the CFC program and a DDS/DMHAS waiver program utilizes the below-listed chart (Chart C1) which assigns PCA hours and the respective budget to fund them based on the number of ADL's found to require *"extensive or greater"* assistance through a UA.

Chart C1 – ADL Extensive Hands-on for Activities of Daily Living (bathing, dressing, toileting, transferring, eating)

ADLs	Hours of PCA per week	Monthly Budget	Annual Budget
1	8.75	$1,076.08	$12,912.90
2	17.50	$2,152.15	$25,825.80
3	26.25	$3,228.23	$38,738.70
4	35.00	$4,304.30	$51,651.60
5	43.75	$5,380.38	$64,564.50

(Exhibit 7, Hearing Record)

9. An individual enrolled in the CFC program and a DDS/DMHAS waiver program can choose to *"trade in some or all of their waiver services for additional CFC services. This will be on an hour to hour trade…If they wish to do so, their* (DDS/DMHAS) *waiver care manager will be responsible for balancing the purchase of the CFC services with their waiver services."* The trade of PCA hours would be to service IADL needs only and is based on the UA LON score. The hours available to trade and their corresponding LON score are displayed in the below-listed chart (Chart C2.)

Chart C2 – IADL Assessed Level of Need (LON) hour allocation	
LON	Hours of PCA per week
1	13.00
2	17.00
3	21.50
4	23.50
5	25.75
6	28.75

(Exhibit 7)

10. On [redacted], 2020, CCC conducted the first UA of the Appellant for the CFC program. The initial assessment identified one ADL need, bathing, that the Appellant required extensive assistance to complete, and the Appellant was enrolled in the CFC program with a total of 34.50 in-home PCA hours per week.[2] (Ms. Steward's testimony, Hearing record)

11. On [redacted], 2021, CCC conducted a second UA of the Appellant for the CFC program. The second assessment identified one ADL need, bathing, that the Appellant required extensive assistance to complete. The Appellant remained enrolled in the CFC program and her in-home PCA hours increased to 47.50 hours per week.[3] (Ms. Steward's testimony, Hearing Record)

12. On [redacted], 2022, CCC conducted a third UA of the Appellant for the CFC program. The third assessment identified two ADL needs, bathing and dressing, that the Appellant required extensive assistance to complete. The Appellant remained enrolled

[2] No LON score provided for the record.

[3] No LON score provided for the record.

in the CFC program and her in-home PCA hours decreased to 46.25 hours per week.[4] (Ms. Steward's testimony, Hearing Record)

13. On [redacted], 2023, CCC conducted a fourth UA of the Appellant for the CFC program. The fourth assessment identified three ADL needs, bathing, dressing, and transferring that the Appellant required extensive assistance to complete. The Appellant received a LON score of six. The Appellant remained enrolled in the CFC program and her in-home PCA hours increased to 55.00 per week.[5] (Exhibit 5, Ms. Steward's testimony, Hearing Record)

14. On [redacted], 2024, CCC conducted a fifth UA of the Appellant for the CFC program. The fifth assessment identified three ADL needs, bathing, dressing, and transferring that the Appellant required extensive assistance to complete. The Appellant received a LON score of six. The Appellant remained enrolled in the CFC program and her in-home PCA hours increased to 55.00 per week. The Appellant's CFC Individual Budget was listed as $74,696.16. (Exhibit 5, Ms. Steward's testimony, Hearing Record)

15. On [redacted], 2024, CCC was notified that the Appellant was enrolled in a DMHAS waiver program. The Appellant receives approximately 32.00 in-home care hours per week from the DMHAS waiver program. (Appellant's testimony, Ms. Santos' testimony)

16. The Appellant has a nurse who comes in daily to administer the Appellant's medication. The nurse is employed through [redacted] and the services are being provided through the DMHAS waiver. The nurse's visits are separate from the 32.00 hours of in-home care the Appellant is receiving through DMHAS. (Ms. Steward's testimony, Appellant's testimony, Hearing Record)

17. On [redacted], 2024, CCC conducted a sixth UA of the Appellant for the CFC program. The sixth assessment was conducted because of CCC's notification that the Appellant was enrolled in a DMHAS waiver program and identified three ADL needs, bathing, dressing, and transferring, that the Appellant required extensive assistance to complete. The UA noted that the Appellant was enrolled in the CFC program and a DMHAS waiver program. No LON score was assessed as the DMHAS waiver program provided the Appellant with in-home care hours to meet her IADL needs. The Appellant remained enrolled in the CFC program and her in-home PCA hours decreased to 26.25 per week. The Appellant's CFC Individual Budget was listed as $35,650.44 and she was granted $15,000.00 for Environmental Accessibility Modifications. The Appellant is not disputing the budget amount or the Environmental Accessibility Modifications amount. (Exhibit 2: Hearing Request dated [redacted], Exhibit 5, Hearing Record)

18. On [redacted], 2024, the Department issued a NOA to the Appellant informing her that her CFC annual budget would be reduced to $35,650.44 and her in-home PCA hours

[4] No LON score provided for the record.
[5] No LON score provided for the record.

would be decreased to 26.25 hours per week effective [redacted], 2024. (Exhibit 1: NOA dated [redacted])

19. The Appellant has recently suffered falls within her home and after the administrative hearing, provided a letter from her physician, Dr. [redacted], MD, which states the following in relevant part: *"This is to let you know that Ms. [redacted] is a patient with hematologic malignancy. She has been frail with recent falls at home and limited in her performance status. Therefore it is imperative to increase her home support services / home health aid and other support measures to increase her safety and functionality at home."* (Appellant's Exhibit A, Appellant's testimony)

20. The Appellant is seeking to increase her PCA hours with CFC from 26.25 hours per week to 55.00 hours per week; the level she was previously receiving from CFC. She feels the PCA services through CFC are more beneficial to her than the in-home care hours provided through the DMHAS waiver. (Appellant's testimony)

21. After the administrative hearing, the Department reviewed the letter submitted by Dr. [redacted] and Attorney Cynthia Cartier provided an email stating the following: *"DSS staff reviewed (the letter). It is their* (the Department's) *position that the medical report does not offer specific requirements that would necessitate additional CFC hours. Ms. [redacted] has significant services in her home, including appropriate PCA hours for her ADL/hands-on needs. The additional needs, specifically the mental health needs she is now presenting, would be best served under the mental health waiver and DMHAS."* (Exhibit 9: Emails from the Department)

22. The Appellant has not contacted DMHAS to modify or trade her in-home care hours that are being provided through the DMHAS waiver program. (Appellant's testimony)

23. The issuance of this decision is timely under Connecticut General Statutes ("Conn. Gen. Stat.") § 17b-61(a), which requires that a decision be issued within [redacted] days of the request for an administrative hearing. The Appellant requested an administrative hearing on [redacted], 2024, and the decision is due not later than [redacted], 2024. However, the hearing record was extended ([redacted]) days to allow for the submission of information from the Appellant and the Department. Therefore, this decision is not due until [redacted], 2024. (Hearing Record)

CONCLUSIONS OF LAW

1. Connecticut General Statutes ("Conn. Gen. Stat.") § 17b-2(6) provides that 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.

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

42 C.F.R. § 441.505 provides for definitions and states in part that activities of daily living (ADLs) mean 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) mean 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 § 441.500(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.

42 C.F.R. § 441.515 provides that States must provide Community First Choice to individuals: (a) On a statewide basis (b) 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.

The Department has the authority to administer the CFC program.

2. Connecticut State Plan Amendment ("SPA") Transmittal No 15-012 effective July 1, 2015 No 15-012 § 5(B) provides for Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADL's, IADL's, and health-related tasks. Service Definition: Services to support the acquisition, maintenance, and enhancement of skill in order for the individual to accomplish ADLs, IADLs and health related tasks. Providers for acquisition, maintenance, and enhancement of skill in order for the individual to accomplish ADLs, IADLs: Attendants. Providers for acquisition, maintenance, and enhancement of skill in order for the individual to accomplish health related tasks: Registered Nurses, Occupational Therapists, Physical Therapists, and Speech Therapists provide maintenance, and enhancement of skill in order for the individual to accomplish health related tasks. These services provide teaching strategies and educational opportunities for individuals to become more independent in their health-related task. These services are provided by licenses staff at home health agencies. Staff are required to complete a certification in person-centered planning. Limit on amount and scope of services to support the acquisition, maintenance, and enhancement of skill in order for the individual to accomplish ADLs, IADLs and health-related tasks. Services associated with skill acquisition, maintenance and enhancement are on a per person basis. Support is time-limited and may not exceed 25 hours per three-month period. It is available only when there is a reasonable expectation that the individual will acquire the skills necessary to perform the task within the time period. Services exceeding this limit may be re-authorized by the Department if significant progress has been made, or if

services are determined to be medically necessary and there is a reasonable expectation that services will support skill acquisition.

SPA 15-012 § 5(A) provides in relevant part 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. 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 participant…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.

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 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.

CFC is correctly providing the Appellant with Attendant Care services to support her ADL needs.

The Appellant's IADL needs are being supported through a DMHAS waiver.

3. SPA No 15-012 § 1(B) provides that the State determines initially, and at least annually, that individuals 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 aged 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.

42 C.F.R. § 441.535(a)-(d) 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.

SPA No 15-012 § 1(C) provides that 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. The assessors at contracted agencies who complete the universal assessment and confirm level of care assess the individual's service needs and level of care at least annually. The individual may be assessed more frequently if his or her functional needs change or if he or she or an authorized representative of the individual so requires. The assessment must include the date of review and the signature of the person documenting the assessment, indicating that the review has been completed and that the individual continues to meet the Level of Care (LOC) criteria. The assessor must also place a case note regarding this assessment in the individual's case management file. The assessor who conducts the assessments and provides ongoing monitoring is either a registered nurse (RN) licenses in Connecticut

or a social worker who is a graduate of an accredited four -year college or university. The nurse or social services worker has a minimum of two years of experience in health care or human services, but may substitute a bachelor's degree in nursing, health, social work, gerontology or a related field for one year of experience.

SPA No 15-012 § 7 provides in relevant part as follows: Confirmation of a participant's level of care is determined by information gathered by assessors at contracted entities during initial assessment and annual re-assessment via face-to-face interviews utilizing the Universal Assessment (UA). Both assessment and re-assessment include a thorough evaluation of the client's individual circumstances. 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 a 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.

The Department via CCC correctly completed both initial and annual in-person, face-to-face UAs of the Appellant's needs, strengths, preferences, and goals.

4. 42 C.F.R. § 441.545(c) provides that a State may choose one or more of the following as the service delivery model to provide self-directed home and community-based attendant services and supports: States have the option of proposing other service delivery models. Such models are defined by the State and approved by CMS.

SPA No 15-012 § 3 provides in relevant part that the State chose other service delivery model. The State has an Other Service Delivery Model that largely aligns with the self-directed model with service budget. The individual has a service plan and an individual service budget based on the person-centered assessment of need. The individual has the opportunity to hire, supervise, and train their own staff as well as the opportunity to manage their own budget, either on their own or with support from someone of their choosing, but not the individual's spouse of legally liable family member. Individual service budgets are based on need grouping categories. Need grouping categories reflect expected resource utilization based on functional needs and risk. There are 8 different categories of need based on the algorithm. Risks identified within the various domains are weighted to determine a score. Domain scores are compiled to determine a total score. Scores are grouped within the 8 categories. The state utilizes the applicable CFC rate as set forth in Attachment 4.19-B in developing individual service budgets.

SPA No 15-012 Attachment 4.19-B provides in relevant part that CFC services are paid pursuant to the current fee schedule for CFC which was set as of July 1, 2015, and is effective for services provided on or after that date.

42 C.F.R. § 441.560(a) provides for service budget requirements. 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 including 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 C.F.R. § 441.560(b) provides that the budget methodology set forth by the State to determine an individual's service 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) Income 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 described 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 C.F.R. § 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.

SPA No 15-012 § (5)(A) 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.

42 C.F.R. § 441.540(c) provides for reviewing the person-centered service plan. The person-centered service plan must be reviewed, and revised upon reassessment of

functional need, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

42 C.F.R. § 441.560(c) provides that the State must have procedures in place that will provide safeguards to individuals when the budgeted service amount is insufficient to meet the individual's needs.

42 C.F.R. § 441.560(e) provides that the budget may not restrict access to other medically necessary care and services furnished under the State plan and approved by the State but which are not included in the budget.

42 C.F.R. § 441.560(f) provides that 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.

The Department correctly developed a service budget based on the Appellant's most recent annual UA and correctly determined that twenty-six and one quarter (26.25) weekly hours of PCA services provided through CFC were sufficient to meet the Appellant's needs based on her requiring extensive or greater assistance to complete three ADL's.

5. Conn. Gen. Stat. § 17b-259b(a) provides that 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 General Statutes § 17b-259b(a).

   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.

SPA No 15-012 § (1)(A) provides in relevant part that the State determines eligibility for Community First Choice (CFC) services in the manner prescribed under 42 CFR § 441.510. To receive CFC services and supports under this section, an individual must be eligible for medical assistance under the State plan and must be in an eligibility group that includes nursing facility services or must have income below 150% of the Federal Poverty Level (FPL) if they are in an eligibility group that does not include Nursing Facility services. Individuals who are receiving medical assistance under the special home and community-based waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Act must continue to meet all 1915(c) requirements and must receive at least one home and community-based wavier service per month. Individuals receiving services through CFC will not be precluded from receiving other home and community-based services 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.

The Department correctly determined that additional PCA hours provided through CFC would duplicate services and are not medically necessary as the Appellant receives IADL support hours through a DMHAS waiver as well as a visiting nurse.

DISCUSSION

During the administrative hearing, the Appellant disputed the reduction in CFC PCA hours from 55 per week to 26.25 per week. The Appellant argued that her medical conditions have recently caused her to fall in her home and she requires the additional hours to allow her to live safely in her home. Additionally, she would prefer the PCA services being provided through CFC over the in-home care services being provided by the DMHAS waiver.

As outlined in FOF # 13-16, the Appellant was previously receiving 55 PCA hours from CFC as they were providing both ADL and IADL services. Once CFC became aware that the Appellant was receiving IADL services through the DHMAS waiver, the PCA hours were reduced so as not to duplicate IADL service hours being provided by DMHAS. The undersigned finds that the 26.25 PCA hours currently provided by CFC to support the Appellant's ADL needs are sufficient to meet medical necessity. The decrease in hours from 55 to 26.25 does not put the Appellant at risk for institutionalization.

However, as outlined in FOF # 9, the Appellant does have the option of contacting her DMHAS case manager to request to "*trade in some or all of* (her)*waiver services for additional CFC services."* This trade would allow the Appellant to have some or all of her IADL in-home services handled through the CFC program instead of DMHAS. Although this trade would not increase the number of hours the Appellant receives in totality, it would align with her preference to have CFC provide the in-home services.

DECISION

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

Joseph Davey
Administrative Hearing Officer

CC: hearings.commops@ct.gov
Attorney Cynthia Cartier, JD, LLM, Staff Counsel, Department of Social Services
Randell Wilson, Manager, CFC

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 §4-1181a (a) of the Connecticut General Statutes.

Reconsideration requests should include specific grounds for the request: for example, indicate what error of fact or law, 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 with **45** days of the mailing of this decision, or **45** days after the agency denies 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 fooled 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 06105-3725. 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 her 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.