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 ID # [redacted]
Client ID # [redacted]
Request # 238670

NOTICE OF DECISION

PARTY

[redacted]
[redacted]
[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2024, the Department of Social Services (the "Department") sent [redacted] (the "Appellant"), a Notice of Action ("NOA") discontinuing his eligibility for participation in the Community First Choice ("CFC") program because he does not meet the Nursing Facility Level of Care ("NFLOC") required for the CFC program.

On [redacted] 2024, the Appellant requested an administrative hearing to contest the Department's decision to discontinue his CFC eligibility.

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, the Appellant requested his administrative hearing be rescheduled.

On [redacted] 2024, the OLCRAH issued a notice rescheduling the administrative hearing for [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 by phone. The following individuals participated in the hearing:

[redacted], Appellant
Cynthia Cartier, JD, LLM, Staff Counsel, for the Department
Janette Steward, RN, Department's representative, CFC program

Sylvia Steinetz, RN, Department's representative, CFC program
Dee Sepulveda, Director of Transitional Services, Agency on Aging of South Central CT
Scott Zuckerman, Hearing Officer

STATEMENT OF THE ISSUE

The issue is whether the Department correctly discontinued the Appellant's eligibility to participate in the CFC program due to failure to meet NFLOC.

FINDINGS OF FACT

1. The Appellant is a recipient of the Medicaid program. (Hearing Record)

2. The Appellant is 31 years old (DOB [redacted]/1993). His diagnoses include Amputee and ABI. (Appellant's Testimony)

3. The Appellant resides alone in the community. (Hearing Record)

4. The Appellant is a participant in the CFC program and was previously authorized for an annual individual budget of $76,733.28 for personal care assistance ("PCA") services under the program. (Hearing Summary, Exhibit 1 Notice of Action, [redacted]/24)

5. On [redacted] 2024, a Universal Case Manager ("UCM") from the Agency on Aging of South Central Connecticut ("AOASCC") conducted a face-to-face assessment with the Appellant at his home. The assessment is a comprehensive annual assessment that includes the evaluation of his physical status, mental status, and functional assessment. The UCM is a social worker who meets the qualifications in the CT State Plan. (Hearing Summary, Exhibit 7: Universal Assessment)

6. The Appellant reports he is independent with bathing and needs equipment to enter and exit the shower, can sit in the shower chair and wash without assistance. The Appellant requires extensive assistance in dressing from the waist down. The Appellant is continent and able to use the toilet independently. When he is unable to get to the bathroom at night, he uses a commode. The Appellant is independent with transferring with the help of his walker. The Appellant is independent with eating. (Exhibit 3: Universal Assessment Outcome and Exhibit 7: Universal Assessment)

7. CFC participants must meet institutional level of care criteria as determined by a Universal Assessment ("UA"). (Exhibit 4: CFC Operating Manual Draft [redacted]/16 and Exhibit 6: Ct State Plan Amendment ("SPA"), [redacted] 2015)

8. The UA outcome reflects that the Appellant is independent in four of his Activities of Daily Living ("ADLs"). The number of ADLs considered extensive, max assistance or total dependence is one. The Appellant is independent in bathing, toileting, transferring, and eating. (Exhibit 3, Hearing Summary, Appellant's Testimony)

9. PCA services are based on the Appellant's level of need at the time of the assessment determined a level of need of one. (Department's testimony and Exhibit

10. On [redacted] 2024, the Department issued a Notice of Action to the Appellant indicating his CFC individual budget equaled $0.00 and that he was no longer eligible for CFC because he did not meet LOC, effective [redacted] 2024. (Exhibit 1: NOA, [redacted]/24)

11. There is no evidence in the hearing record that the Appellant requires PCA care based on medical necessity. (Hearing Record)

12. A clinical nurse at the Department reviewed the comprehensive assessment of needs, including the detailed assessment of his ADLs, and determined that the outcome was correct. (Hearing Record, Department's Testimony)

13. The issuance of this decision is timely under section 17b-61(a) of the Connecticut General Statutes, which requires that the Department issue a decision within 90 days of the request for an administrative hearing. The Appellant requested an administrative hearing on [redacted] 2024, with this decision due [redacted] 2024. However, the hearing, which was originally scheduled for [redacted], 2024, was rescheduled for [redacted] 2024, at the request of the Appellant, which caused a 21-day delay. Because this 21-day delay resulted from the Appellant's request, this decision is not due until [redacted], 2024, and is therefore timely. (Hearing Record)

CONCLUSIONS OF LAW

1. Section 17b-2 of the Connecticut General Statutes 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. 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. 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.

The Appellant does not require hands-on assistance with four out of five of his ADLs and is independent with eating, toileting, bathing, and transferring.

5. 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.

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

SPA No 15-012 § 7 provides in pertinent part that 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.

The Department, through its provider AOASCC, correctly conducted a face-to-face utilizing the UA of the Appellant's functional needs.

6. 42 C.F.R. § 441.510 provides that to receive Community First Choice services and supports under this section, an individual must meet the following requirements: (a) Be eligible for medical assistance under the State plan; (b) As determined annually-(1) Be in an eligibility group under the State plan that includes nursing facility services; or (2) If in an eligibility group under the State plan that does not include such nursing facility services, have an income that is at or below 150 percent of the Federal poverty level (FPL). In determining whether the 150 percent of the FPL requirement is met, States must apply the same methodologies as would apply under their Medicaid State plan, including the same income disregards in accordance with section 1902(r)(2) of the Act; and, (c) Receive a determination, at least annually, that in the absence of the home and community-based attendant services and supports provided under this subpart, the individual would otherwise require the level of care furnished in a hospital, a nursing facility, an intermediate care facility for individuals with intellectual disabilities, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over, if the cost could be reimbursed under the State plan. The State administering agency may permanently waive the annual recertification requirement for an individual if: (1) It is determined that there is no reasonable expectation of improvement or significant change in the individual's condition because of the severity of a chronic condition or the degree of impairment of functional capacity; and (2) The State administering agency, or designee, retains documentation of the reason for waiving the annual recertification requirement. (d) For purposes of meeting the criterion under paragraph (b) of this section, individuals who qualify for medical assistance under the special home and community-based waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Act must meet all section 1915(c) requirements and receive at least one home and community-based waiver service per month.(e) Individuals receiving services through Community First Choice will not be precluded from receiving other home and community-based long-term care services and supports through other Medicaid State plan, waiver, grant or demonstration authorities.

   42 C.F.R. § 441.520 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.

The Department correctly determined, based on the UA, that the Appellant is not at risk of being institutionalized and does not meet the LOC required to receive CFC services.

7. Section 17b-259b of the Connecticut General Statutes defines medically necessary and medical necessity. (a) provides for purposes of the administration of the medical assistance programs by the Department of Social Services, "medically necessary" and "medical necessity" mean those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.

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

   “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 ███ 2024, AOASCC correctly issued a Notice of Action Service Budget Reduction letter to the Appellant notifying him that his CFC budget based on

his reassessed Level of Need is $0.00 and that based on his reassessed level of need, he no longer meets the level of care for the CFC program.

DECISION

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

Scott Zuckerman
Scott Zuckerman
Fair Hearing Officer

CC: hearings.commops@ct.gov
Randell Wilson, DSS, CFC Manager
Cynthia Cartier, DSS Staff Counsel

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.