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 # [redacted]
Request # 243131

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2024, the Department of Social Services (the "Department") issued a Notice of Action ("NOA") to [redacted] (the "Appellant") and [redacted], the Appellant's guardian ("Guardian") reducing the recipient's Community First Choice ("CFC") Individual Budget from $47,533.92 to $39,605.58 annually, effective [redacted] 2024, based on a reassessment of the recipient's level of need.

On [redacted] 2024, the Appellant requested an administrative hearing to contest the Department's reduction of his budget.

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, the OLCRAH held an administrative hearing by phone. The following individuals were present at the hearing:

[redacted], Appellant's mother and Guardian
Donna Jordan, Care Manager, CT Community Care
Cynthia Cartier, Staff Counsel, OLCRAH, Department of Social Services
Amy Santos, Manager, CT Community Care, Community First Choice

Orenthia Channer, RN, Department of Social Services, Community First Choice
Scott Zuckerman, Hearing Officer

The Appellant was not present for the administrative hearing.

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department correctly reduced the Recipient's CFC service budget based on a reassessment of the Appellant's level of need.

FINDINGS OF FACT

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

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

3. On [redacted] 2022, the Connecticut Department of Developmental Services ("DDS") conducted a Level of Need Assessment (LON") for the Appellant. He has diagnoses of Intellectual Disability, Autism, and OCD. (Exhibit 4: DDS LON and Hearing Summary)

4. The Appellant accesses his CFC services through the DDS waiver. DDS acts as a Medicaid operating partner under a Memo of Understanding with the Department. DDS works as a partner with the Department. (Hearing Record, Department's Testimony)

5. [redacted] is the Appellant's mother and guardian. She is his primary support. (Exhibit 6, Hearing Record)

6. The Appellant resides on his own with a roommate and supports in the community. (Hearing Record)

7. The Appellant is 30 years old ([redacted]/1994). (Exhibit 4)

8. The Appellant receives services and support from DDS leading to the acquisition, improvement, and/or retention of skills and abilities to prepare an individual for work and community participation or support meaningful socialization, leisure, and retirement. (Hearing Record)

9. The Appellant receives his IADL ("Instrumental Activities of daily living") and behavioral needs through the DDS Waiver plan. (Hearing Record)

10. The DDS waiver care plans do not include funding for the ADL component of the budget. Assistance for ADL needs is provided by the Department's home health benefit. CFC does not provide services for behavioral needs or instrumental activities of daily living ("IADLs") when they are being serviced under the DDS waiver. (Hearing Record)

11. The Appellant's CFC budget before [redacted], 2024, was approved for 35 hours weekly of personal care attendant ("PCA") services equaling $47,533.92 yearly. (Exhibit 1: NOA, Hearing Summary)

12. On [redacted] 2024, CFC conducted an annual assessment of the Appellant's. The assessment was conducted face-to-face with a social worker from Connecticut Community Care ("CCC") and the Appellant's guardian. The CCC social worker documented that the Appellant requires total dependence with the following three activities of daily living ("ADLs"): bathing, dressing, and toileting. (Exhibit 5: Department's Assessment)

13. CCC is the Department's contractor that assesses the level of care and service needs for CFC services. (Hearing Record)

14. Each ADL translates to 8.75 service hours for a total of 26.25 (8.75 x 3 = 26.25) hours weekly for Budget C – CFC combined with the DDS waiver. (Hearing Summary and Department's Testimony and Exhibit 3: CFC Budget Categories)

15. A clinical nurse at the Department reviewed the Appellant's reassessment and determined that 26.25 hours weekly was appropriate to maintain the Appellant in the community. (Hearing Record)

16. On [redacted], 2024, the Department gave the Appellant and his Guardian a Notice of Action Community First Choice Program Service Budget Reduction letter. The letter indicated that the Department had previously authorized a CFC individual budget of $47,533.92. The new revised annual budget is reduced to $39,605.58 or approximately 26.25 hours of PCA services weekly. (Exhibit 1: Notice of Action, [redacted]/24)

17. 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 not due until [redacted], 2024. (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. Title 42 C.F.R. § 441.500(b) provides that Community First Choice is designed to make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands-on assistance, supervision, or cueing.

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

and community-based waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Act must meet all section 1915(c) requirements and receive at least one home and community-based waiver service per month.

(e) Individuals receiving services through Community First Choice will not be precluded from receiving other home and community-based long-term care services and supports through other Medicaid State plan, waiver, grant or demonstration authorities.

5. 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.

6. 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.

    The Department was correct when it determined that the Appellant requires total dependence with bathing, dressing, and toileting.

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. 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).

The Department correctly determined that the Appellant has been awarded an annual budget through the DDS waiver. The budget for services provided through DDS along with the 26.25 hours approved by CFC and the natural supports provided by the Appellant's guardian do not place the Appellant at risk of institutionalization.

Based on the evidence provided, the reduction in the Appellant's CFC budget from $47,533.92 yearly or 35 hours per week to $39,605.58 or 26.25 hours per week is sufficient to meet the Appellant's needs. The Department correctly determined additional PCA hours are not medically necessary for the Appellant to meet his functional needs because the type, frequency, and duration of such services are not clinically appropriate at this time.

DECISION

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

Scott Zuckerman
Scott Zuckerman
Hearing Officer

Pc: Community Options, Department of Social Services, Central Office
Randell Wilson, Manager, Department of Social Services, Central Office
Cynthia Cartier, Staff Counsel, Department of Social Services, Central Office

RIGHT TO REQUEST RECONSIDERATION

The appellant has the right to file a written reconsideration request within **15** days of the mailing date of the decision on the grounds there was an error of fact or law, new evidence has been discovered or other good cause exists. If the request for reconsideration is granted, the appellant will be notified within **25** days of the request date. No response within 25 days means that the request for reconsideration has been denied. The right to request a reconsideration is based on § 4-181a (a) of the Connecticut General Statutes.

Reconsideration requests should include specific grounds for the request: for example, indicate what error of fact or law, what new evidence, or what other good cause exists.

Reconsideration requests should be sent to: Department of Social Services, Director, Office of Administrative Hearings and Appeals, 55 Farmington Avenue Hartford, CT 06105.

RIGHT TO APPEAL

The appellant has the right to appeal this decision to Superior Court within **45** days of the mailing of this decision, or **45** days after the agency denies a petition for reconsideration of this decision, provided that the petition for reconsideration was filed timely with the Department. The right to appeal is based on § 4-183 of the Connecticut General Statutes. To appeal, a petition must be filed at Superior Court. A copy of the petition must be served upon the Office of the Attorney General, 165 Capitol Avenue, Hartford, CT 06106 or the Commissioner of the Department of Social Services, 55 Farmington Avenue Hartford, CT 06105. A copy of the petition must also be served on all parties to the hearing.

The 45 day appeal period may be extended in certain instances if there is good cause. The extension request must be filed with the Commissioner of the Department of Social Services in writing no later than 90 days from the mailing of the decision. Good cause circumstances are evaluated by the Commissioner or the Commissioner's designee in accordance with § 17b-61 of the Connecticut General Statutes. The Agency's decision to grant an extension is final and is not subject to review or appeal.

The appeal should be filed with the clerk of the Superior Court in the Judicial District of New Britain or the Judicial District in which the appellant resides.