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

[redacted] **2018**
Signature Confirmation

Client ID #[redacted]
Request #117182

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2018, the Department of Social Services (the "Department") issued a Notice of Action ("NOA") to [redacted] (the "Appellant"). The notice stated that the Appellant's Community First Choice ("CFC") Individual Budget amount would be reduced from $26,740.44 to $14,315.90 per year, effective [redacted] 2018, based on a reassessment of the Appellant's level of need.

On [redacted] 2018, the Appellant requested an administrative hearing to contest the Department's reduction in his level of care.

On [redacted], 2018, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted], 2018.

On [redacted], 2018, the Appellant requested the hearing be rescheduled for additional paperwork.

On [redacted] 2018, OLCRAH issued a notice scheduling the administrative hearing for [redacted] 2018.

On [redacted], 2018, 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.

The following individuals were present at the hearing:

[redacted], Appellant
Kari Echevarria, Department of Social Services, Community Options
Dee Sepulveda, South Central Area on Aging ("AASCC")
Scott Zuckerman, Hearing Officer

The hearing record remained open for the Appellant to review the Department's exhibits and for the Department to clarify the reduction in PCA hours. The Department provided a narrative explaining their action. The Appellant was given the opportunity to respond to the exhibits and narrative, no response was received. On [redacted] 2018, the hearing record closed.

STATEMENT OF THE ISSUE

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

FINDINGS OF FACT

1. On [redacted], 2013, the Appellant suffered injuries to his wrist, arm, and legs as a result of a motor vehicle accident. (Appellant's testimony)

2. The Appellant suffered from a broken fibula, which required metal anchors to be placed in his right wrist. The Appellant has nerve damage in his wrist, no feeling in his fingers, and has a hard time grasping anything. (Hearing Record)

3. On [redacted], 2016, the Appellant completed an assessment for CFC services. At that time, the Appellant was assessed as needing a $26,740.44 annual budget for limited assistance with the following Activities of Daily Living ("ADLs"): bathing dressing and transferring. His level of need was scored at a 4 and he was determined to require nursing facility ("NF") level of care. (Hearing Summary, Exhibit 3: Universal Assessment, [redacted]/16 and Ex. 4: CFC Budget Approval Form, [redacted]/16)

4. AASCC is the Department's contractor for the purpose of assessing level of care and service needs for CFC services. (Hearing Record)

5. On [redacted] 2016, the Department approved the Appellant's initial service plan with a budget of $26,740.44 to allow the Appellant to receive 30 hours per week for a PCA to assist him with his activities of daily living ("ADLs") and his instrumental activities of daily living ("IADLs"). (Hearing Summary, Exhibit 4: Community First choice – Budget Worksheet)

6. On [redacted], 2018, the Appellant completed a reassessment of his level of care for CFC services. The Universal Care Manager ("UCM") from AASCC met with the Appellant and determined the Appellant needs limited assistance with the following ADL's: bathing and dressing. The UCM determined the Appellant is independent in toileting, transferring and eating. His level of need was scored at 2 and was determined to require nursing facility ("NF") level of care. (Hearing Summary and Exhibit 2: Universal Assessment Outcome Form, [redacted]/18, Ex. 5: Universal assessment [redacted]/18)

7. On [redacted] 2018, the Department gave the Appellant a Notice of Action Community First Choice Program Service budget Reduction letter. The letter stated that the Department previously authorized a CFC individual budget of $26,740.44. The revised budget is $14,315.90 or 17 hours of Personal Care Assistant ("PCA") services per week. (Exhibit 7: Notice of Action, [redacted]/18)

8. The Appellant is Medicaid recipient. (Hearing Record)

9. The Appellant is [redacted] years of age. (Appellant's testimony)

10. The Appellant lives alone. (Appellant's testimony)

11. The Appellant requires limited assistance with bathing. The Appellant requires assistance to wash on his left side due to limitations with his right wrist. (Appellant's testimony, Exhibit 5: Universal Assessment, [redacted]/18)

12. The Appellant is Independent in the area of personal hygiene. (Ex. 5)

13. The Appellant requires limited assistance with dressing his upper body by having the PCA guide his arm into a shirt. (Appellant's testimony, Ex. 5)

14. The Appellant no longer requires the assistance of a PCA for transferring as he is independent with this ADL. (Appellant's testimony and Ex. 5)

15. The Appellant requires assistance in performing the following Instrumental Activities of Daily Living ("IADL"): housework and meal preparation. (Appellant's testimony and Ex. 5)

16. The Appellant has the assistance of a PCA for three hours in the morning to assist him with dressing for the day, completing housework, cooking breakfast and taking him to appointments. (Appellant's testimony, Ex. 5)

17. The Appellant has the assistance of a PCA for three hours in the evening to assist him with washing, preparing his meals, and for getting dressed for bed. (Appellant's testimony, Ex. 5)

18. The Appellant receives PCA assistance 5 days weekly for a total of 30 hours. (Hearing Record)

19. The Appellant's cognitive status is alert and oriented. (Exhibit 2: Universal Assessment Outcome Form and Ex. 5)

20. The Appellant does not require medication support beyond setup. (Ex. 2)

21. The Appellant does not exhibit any behavioral concerns. (Ex. 2)

22. The Appellant has improved in the area of meal preparation, requiring limited assistance. He is able to prepare a sandwich; his PCA's prepare hot meals. The Appellant had required extensive assistance when first evaluated in 2016. (Appellant's testimony, Exhibit 3 and Ex. 5)

23. The Appellant has improved in the area of housework, requiring limited assistance. He is able to do laundry and vacuums at times. The Appellant had required extensive assistance when first assessed in 2016. (Appellant's testimony, Exhibit 3: Universal Assessment [redacted]/16 and Ex. 5)

24. The Appellant has improved in his ability to go up and down stairs and is performing this IADL independently. The Appellant had required supervision during the initial assessment in 2016. (Appellant's testimony, Ex. 3 and Ex. 5)

25. The Appellant is independent in shopping for food and household items. The Appellant had required limited assistance in lifting and putting away items during the initial assessment for services. (Ex. 3 and Ex. 5)

26. The Appellant has improved in the area of transportation including getting in and out of cars independently. The Appellant had required limited assistance with help getting out of a car. (Ex. 3 and Ex. 5)

27. On [redacted] 2018, OLCRAH conducted an Administrative Hearing. The Appellant did not provide additional evidence. The Appellant was given the opportunity to respond to evidence submitted by the Department, no response was received. (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. Section 17b-259b of the Connecticut General Statures states that "Medically necessary" and "medical necessity" defined.

(a) 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 the Appellant requires the level of care furnished in a nursing facility in the absence of the home and community-based attendant services and supports as stated in Title 42 CFR Code of Federal Regulations (“CFR”)§ 441.510.

3. Title 42 of the § 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.

4. 42 CFR § 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.

5. 42 CFR § 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.

6. 42 CFR § 441.510 address 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.

7. State Plan Under Title XIX of The Social Security Act states: Community First Choice State Plan Option Pursuant to Section 1915(k) of the Social Security Act provides that:

1. Eligibility

A. The State determines eligibility for Community First Choice (CFC) services in the manner prescribed under 42CFR § 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 l 902(a)(lO)(A)(ii)(VI) of the Act must continue to meet all 1915(c) 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.

The Department correctly determined the Appellant meets the eligibility requirements for CFC Services.

8. 42 CFR § 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.** (Emphasis added)

(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 that the Appellant no longer requires assistance with transferring but continues to require limited assistance with bathing and dressing.

The Department correctly determined the Appellant has made improvements in performing his IADLS of meal preparation, housework, climbing stairs, shopping, and assistance with transportation.

9. 42 CFR § 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.

The Department correctly completed an assessment through its contractor, AASCC to determine the Appellant's service plan and service budget.

Based on the evidence provided, the reduction in the Appellant's weekly PCA hours from 30 hours per week to 17 hours per week is adequate to meet the Appellant's functional needs with regards to his medical condition and overall health. The Appellant no longer requires PCA assistance with transferring and has made improvements in independently performing IADL's of meal preparation, housework, climbing stairs, shopping and transportation.

The Department correctly determined that there is no medical evidence that the reduction in the Appellant's weekly PCA hours and budget service plan places the Appellant at risk of institutionalization.

The Department correctly determined that the reduction in the Appellant's weekly PCA hours from 30 to 17 still provides for the welfare and safety of the Appellant in his home.

DECISION

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

Scott Zuckerman
Hearing Officer

C: Sallie Kolreg, DSS, Central Office
Lisa Bonetti, DSS, Central Office
Dawn Lambert, DSS, Central Office
Christine Weston, DSS, 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 06105-3725.

RIGHT TO APPEAL

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

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

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