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

Case # [redacted]
Client ID # [redacted]
Request # [redacted]

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 "Recipient"). The notice stated that the Recipient's Community First Choice ("CFC") Individual Budget amount would be reduced from $34,724.01 to $7,368.48 per year, effective [redacted], 2018, based on a reassessment of the Recipient's level of need.

On [redacted] 2018, [redacted] (the "Appellant"), requested an administrative hearing to contest the Department's reduction in the Recipient's level of need.

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, 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 via telephone
[redacted], Appellant's spouse
Christine Weston, Department of Social Services, Community Options
[redacted], Recipient
Carla Hardy, Hearing Officer

The hearing record remained open for the Department to submit a copy of the Medicaid State Plan Amendment ("SPA"). The SPA 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 Recipient's CFC service budget based on a reassessment of the Recipient's level of need.

FINDINGS OF FACT

1. On [redacted] 2016, the Recipient was initially authorized for CFC services. (Department's Testimony)

2. The Department approved the Recipient's initial service plan with a budget of $34,718.38 for a Personal Care Assistant ("PCA") to assist him with his activities of daily living ("ADLs"), his instrumental activities of daily living ("IADLs"), health related goals and other services. (Department's Testimony)

3. On [redacted] 2017, the recipient completed a Level of Need ("LON") assessment with the Department of Developmental Services ("DDS") services. (Exhibit 3: CT DDS Level of Need Assessment and Screening Tool, [redacted])

4. The Recipient has a primary diagnosis of intellectual disability. In addition, he is diagnosed with a non-life threatening allergy, a foot or nail condition and being overweight. He is a compulsive eater, borderline hypertensive and a borderline diabetic. He has a mood disorder. (Exhibit 3; Exhibit 5: Revised CFC Individual Budget)

5. The Recipient does not have any prescribed treatments or care such as catheters, needle injections, nebulizers, oxygen, respiratory suctioning, postural drainage, ostomy, tracheostomy, tube feeding or artificial ventilator. (Exhibit 3)

6. The Recipient does not require hands on or direct care from a nurse. (Exhibit 3)

7. The Recipient is able to get dressed, but needs prompting, or may need assistance with choosing weather appropriate clothing. (Exhibit 3, Exhibit 5, Spouse's Testimony)

8. The Recipient is able to bathe himself, but may need assistance regulating the water temperature or some type of prompting. (Exhibit 3, Exhibit 5, Spouse's Testimony)

9. The Recipient can be incontinent at times and requires extensive assistance with toileting. (Exhibit 3, Exhibit 5, Spouse's Testimony)

10. The Recipient requires cueing and supervision with eating. He overeats and eats too quickly. (Exhibit 3, Exhibit 5; Spouse's Testimony)

11. The Recipient walks without assistance and does not need assistive devices such as a walker or cane. (Exhibit 3, Exhibit 5, Spouse's Testimony)

12. The Recipient requires assistance with taking medications, using the telephone, completing household chores, shopping, meal preparation, budgeting and transitioning from one task to another. (Exhibit 3, Hearing Summary)

13. DDS acts as a Medicaid operating partner under a Memo of Understanding with the Department. It operates its waiver program based on Medicaid funds. (Department's Testimony, Hearing Summary)

14. The Recipient receives an annual budget of $22,311.00 from DDS. (Spouse's Testimony)

15. Individual Day Supports is a DDS waiver service that provides the Recipient with approximately 25.00 hours per week of services or $22,311.00 annually. (Department's Testimony)

16. On [redacted], 2018, the Recipient completed a reassessment for CFC services. Based on the fact that DDS acts as a Medicaid operating partner, the Department reviewed the DDS assessment that was completed within the previous 12 months in addition to an assessment of needs related to core Activities of Daily Living ("ADLs") in its evaluation. The CFC assessment was conducted face-to-face by a social worker with the Area Agency of South Central Connecticut ("AASCC"). (Hearing Summary)

17. The Recipient was determined to need oversight or cueing with bathing, eating and dressing his upper and lower body. He was determined to need extensive assistance with toileting and to be independent with transferring. At that time, the Recipient was assessed as needing an annual budget of $7,368.48 for extensive assistance with toileting. His level of need was scored at a 5 and he was determined to require nursing facility ("NF") level of care. (Exhibit 2: Universal Assessment, [redacted]/18; Exhibit 5; Hearing Summary)

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

19. On [redacted] 2018, the Department gave the Recipient and the Appellant's spouse 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 $34,724.01. The revised annual budget is listed as $7,368.48 or approximately 8.50 hours of PCA services per week. (Exhibit 6: Notice of Action, [redacted]/18)

20. The recipient has been approved for 8.75 hours, not 8.50 hours of PCA services per week. (Department's Testimony)

21. The Appellant's spouse is the Recipient's mother. (Hearing Record)

22. The Recipient is receiving Medicaid. (Hearing Record)

23. The Recipient is [redacted] years (DOB [redacted]) of age. (Exhibit 3)

24. The Recipient's mother is his primary caregiver. (Exhibit 3, Hearing Record)

25. The Appellant is the Recipient's secondary caregiver. (Exhibit 3)

26. The Recipient lives with his parents. His needs are met by his caregivers when the Recipient is at home. (Exhibit 3)

27. The Recipient does not require a caregiver to be awake during the night. (Exhibit 3)

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 ("CFR") 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 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.

4. Title 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.

5. Title 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.

(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 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.

   The Department was correct when it determined that the recipient requires hands on assistance with toileting, supervision and cueing with bathing, dressing and eating and that the recipient is independent with transferring.

   The Department was correct when it determined that the recipient requires assistance with his IADLs.

7. 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.

8. 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.

9. Connecticut State Plan Amendment ("SPA") no.15-012 (5)(A), pursuant to section 1915(k) of the Social Security Act, 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.

The Department was correct when it determined that the recipient's parents are a source of natural support for his ADLs and IADLs.

10. 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 Recipient has been awarded an annual budget of $22,311.00 from DDS. The $22,311.00 budget or estimated 25 weekly hours of services provided through DDS along with the 8.75 hours approved by CFC and the natural supports provided by the Recipient's parents do not place the Recipient at risk of institutionalization.

Based on the evidence provided, the reduction in the Recipient's PCA budget from $34,724.01 yearly to $7,368.48 or to 8.75 hours per week is sufficient to meet the Recipient's needs. The Department correctly determined additional PCA hours are not medically necessary for the Recipient to meet his functional needs because the type, frequency and duration of such services are not clinically appropriate at this time given that other services and natural supports are currently in place.

DECISION

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

Carla Hardy
Hearing Officer

Pc: Sallie Kolreg, 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.