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

[redacted] **2018**
Signature Confirmation

[redacted]
Request # 120162

NOTICE OF DECISION
PARTY

[redacted]

PROCEDURAL BACKGROUND

[redacted], 2018, the Department of Social Services (the "Department") issued a Notice of Action ("NOA") to [redacted] (the "Appellant"), discontinuing her benefits under the Community First Choice ("CFC") Program effective [redacted] 2018.

[redacted], 2018, the Appellant requested an administrative hearing to contest the Department's decision to discontinue such benefits.

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

[redacted], 2018, in accordance with sections 17b-60, 17b-61 and 4-176e to 4-189 inclusive, of the Connecticut General Statutes, OLCRAH held an administrative hearing.

The following individuals were present at the hearing:

[redacted]
Deborah Fox, Department's Representative
Veronica King, Fair Hearing Officer

The hearing record remained open for the submission of additional information. On [redacted] 2018, the hearing record closed.

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department's decision to discontinue the Appellant's benefits under the Community First Choice ("CFC") Program was correct.

FINDINGS OF FACT

1. The Appellant is a participant in the Medicaid Husky C program as administered by the Department. (Hearing Record)

2. The Appellant is fifty-four (54) years old, DOB [redacted]. (Hearing Record)

3. The Appellant resides at first floor of a family-house and her daughter and Personal Care Assistant ("PCA") lives at the second floor. (Appellant's Testimony)

4. The Appellant's medical primary diagnosis consists of Cirrhosis of the liver. Her other medical diagnosis are Rheumatoid Arthritis, Diabetes type 2, Neuropathy, asthma, hypertension, peripheral edema, anxiety, depression, diverticulosis, GERD, hypothyroid disease, constipation, anemia, glaucoma, history of ETOH, osteoporosis ventricular premature complex, and migraines. (Hearing Record)

5. On 2014, the Appellant was hospitalized with complication related to cirrhosis of the liver. (Appellant's PCA and daughter's Testimony and Appellant's Exhibit B: Medical records)

6. On 2016, the Appellant was hospitalized with complication related to her diabetes type 2. (Appellant's PCA and daughter's Testimony and Appellant's Exhibit B: Medical records)

7. The Appellant applied for applied for PCA services under the Community First Choice ("CFC") program. (Department Representative's Testimony)

8. On [redacted] 2017, the Department authorized a CFC Individual Budget for the Appellant of $56,947.83 for PCA services. (Hearing Record and Exhibit 3: Notice of Action, [redacted]/18)

9. The Appellant was receiving services under an approved plan when the eligibility for the CFC services was redesigned to meet new federal

guidelines to implement the revised Universal Assessment ("UA"). (Hearing Record)

10. Area Agency of South Central Connecticut ("AASCC") is the Department's contractor for the purpose of assessing level of care and services needs for CFC services. (Hearing Record)

11. [redacted] 2018, the Appellant participated in a required annual comprehensive reassessment for CFC services. The UA was conducted face to face by a qualified AASCC social worker. (Hearing Record)

12. The UA determined that the Appellant is independent with the following Activities of Daily Living ("ADLs"): bathing, transferring, toileting, and eating/feeding. The Appellant needs limited assistance with dressing due to her limited Range of Motion. She reported that she cannot lift her arms above her shoulders. (Exhibit 10: Universal Assessment, Hearing Record and Appellant's Testimony)

13. The Appellant is reported that she uses a walker sometimes. The hearing officer observed the Appellant walking independently. (Hearing Record and Appellant's Testimony)

14. For Instrumental Activities of Daily Living ("IDALs") the Appellant is dependent with housework and meal preparation, she reported that the PCAs clean her house and do her laundry. She prepares some light meals and does some light housework, however due to the pain and limited ROM of shoulders; her PCAs do the most of the cleaning and laundry. She sets her own medication and takes independently. She manager her finances on her own. The Appellant goes to the store with her PCA for transportation; she gets in and out of the car and pays the cashier independently. (Appellant's Testimony, Hearing Record, Exhibit 10)

15. The Appellant does not have a problem with her memory. She is fully oriented to self, place, and time. (Hearing Record, Exhibit 10 and Appellant's Exhibit B: Medical Records)

16. Clinical nurses at the Department reviewed the Appellant's medical and total needs to affirm if nursing home level of care was medically necessary. (Hearing Record)

17. [redacted], 2018, the Department issued a notice of action to the Appellant. The notice stated: "Today we reassessed your Level of Need and your revised CFC Individual Budget is $00.00. This budget amount is equal to about 0 hours of Personal Care Assistant (PCA) per week. Effective date of budget reduction [redacted] 2018. Date of discontinuance, no longer eligible for CFC services [redacted]/18. Upon reassessment, you no

longer meet the level of care for CFC. 42 CFR 441.530." (Exhibit 3: Notice of Action, [redacted]/18)

18. At the hearing, the Appellant submitted her medical records. (Hearing Record and Appellant's Exhibit B)

19. [redacted] 2018, routine follow up visit with her primary doctor, the Appellant denied any problems with the activities of daily living. (Appellant's Exhibit B)

20. The Appellant has depression and receives active treatment. (Appellant's Testimony, Hearing Record and Appellant's Exhibit B)

21. The Appellant has diabetes type 2 and receives active treatment. (Appellant's Testimony, Hearing Record and Appellant's Exhibit B)

22. The Appellant has cirrhosis of the liver and receives active treatment. (Appellant's Testimony, Hearing Record and Appellant's Exhibit B)

23. The Department reviewed the Appellant's medical records submitted by the Appellant at the hearing. The Department determined that there is no indication that the Appellant meets the level of care of institutionalization in a skilled nursing facility. She is able to make decisions about her care, the medication she does and does not take. (Exhibit 11: Department's email, [redacted]/18)

24. The Department determined that the Appellant does not meet the medical criteria for institutional level of care and therefore ineligible for services under the CFC program. (Hearing Record)

CONCLUSIONS OF LAW

1. Connecticut General Statute ("CGS") § 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.

2. Title 42 of the Code of Federal Regulations ("CFR") § 441.500(a) provides 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 of the CFR § 441.500(b) provides that the 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.

   Title 42 of the CFR § 441.505 defines *activities of daily living (ADLs)* as basic personal everyday activities, including but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

   Title 42 of the CFR § 441.505 defines *instrumental activities of daily living (IADLs)* as 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.

4. Title 42 of the CFR § 441.510 provides that to receive Community First choice services 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 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, State must apply the same methodologies as would apply under their Medicaid State plan, including the same income disregards in accordance with section 1902(r0(2) of the Act; and
   c. Receive a determine, at least annually, that in the absence of the home and community-based attendant services and support 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 individual 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. The Department correctly determined the Appellant is subject to an annual review for the purpose of determining whether in the absence of home and community-based attendant services and supports provided under the CFC program, the Appellant would otherwise require the level of care furnished in a hospital, a nursing facility, intermediate care facility for individuals with intellectual disabilities, or an institution providing psychiatric services for individuals under age 21.

6. Title 42 of the CFR § 441.535 provides that 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 necessitation revisions to the person-centered service plan, and at the request of the individual.

d. Other requirements as determined by the Secretary.

7. State Statute 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. [CGS § 17b-259b(a)]

8. State Statute provides that clinical policies, medical policies, clinical criteria or any other generally accepted clinical practice guidelines used to assist in evaluating the medical necessity of a requested health service shall be used solely as guidelines and shall not be the basis for a final determination of medical necessity. [CGS § 17b-259b(b)]

9. The Department correctly determined the Appellant does not require continuous supervision for an uncontrolled or unstable chronic condition or supervision for a chronic condition requiring substantial assistance on a daily basis.

10. The Department correctly determined the Appellant does not meet the eligibility criteria as established in federal regulations to support the medical necessity for CFC services because the Appellant’s medical condition does not require the level of care furnished in a hospital, a nursing facility, an intermediate care facility or an institution providing psychiatric services. The Appellant does not meet the criteria of an individual who requires institutional level of care.

11. The Department correctly determined that there is no medical evidence to support the medically necessary criteria to authorize payment under the CFC Program.

12. [redacted] 2018, the Department correctly issued a notice of action to the Appellant informing her that her benefits under the CFC program will end on [redacted], 2018.

DISCUSSION

Community First Choice is a benefit available to Medicaid recipients under the State Plan to provide services in home to individuals who would otherwise require institutionalization as determined by state standards.
Past records and evidence presented at this hearing supports that the Appellant reported no problems with her ADL's and only times there were any reported challenges were during acute illness and post hospitalizations occurred in 2014, 2015 and 2016. The Department suggested that the Appellant could benefit from some in home Physical Therapy and Occupational Therapy evaluation, to make sure she has the appropriate durable medical equipment to remain safely in her home. The Appellant's doctor can order the suggested therapies as well further education by a home health nurse as the Appellant has a number of medical diagnosis and multiple medications.

There is no question that the Appellant is an individual with medical challenges, however at this time the Appellant does not meet nursing facility level of care and therefore she is no longer eligible for CFC program.

DECISION

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

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Veronica King
Fair Hearing Officer

CC: Dawn Lambert, DSS – Central Office
Christin Weston, DSS – Central Office
Deborah Fox, DSS- Central Office
Lisa Bonetti, DSS – Central Office
Sallie Kolreg, 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.

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.