**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**

[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 "Appellant"). The notice stated that the Appellant's Community First Choice ("CFC") Individual Budget amount would be reduced from $41,880.00 to $0.00 per year, effective [redacted] 2018, based on a reassessment of the Appellant's level of care.

On [redacted] 2018, the Appellant requested an administrative hearing to contest the Department's reduction in her 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]
Allison Weingart, Department of Social Services, Community Options

Carla Hardy, Hearing Officer

The hearing record remained open for the Appellant and the Department to submit additional evidence. Additional evidence 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 reduction in the recipient's level of care.

## FINDINGS OF FACT

1. On [redacted] 2016, the Appellant applied for CFC services. (Department's Testimony)

2. The Appellant was initially authorized for CFC services in [redacted] 2017. (Appellant's Testimony)

3. The Department approved the Appellant's initial service plan with a budget of $41,880.00 (Exhibit 2: Notice of Action, [redacted]/18)

4. On [redacted] 2018, the Appellant completed a reassessment for CFC services. The CFC assessment was conducted face-to-face by a social worker with Connecticut Community Care ("CCC"). At that time, the Appellant was assessed as needing extensive assistance with dressing. Her level of need was scored at a 1 and she was determined to not require nursing facility ("NF") level of care. (Exhibit 3: Universal Assessment, [redacted]18; Hearing Summary)

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

6. The Appellant has a primary diagnosis of anxiety. Other diagnoses include osteoarthritis, dementia, neuropathy, asthma, myocardial infarction, bipolar disorder, depression, tuberculosis, urinary tract infection, gastroesophageal disease, anemia, blood disorder, Rhabdomyolysis, osteomyelitis, endocarditis, cystadenoma and Crohn's Disease. (Exhibit 3, Appellant's Exhibit C: InterCommunity medical notes)

7. The Appellant is not receiving active treatment for dementia. It is being monitored. (Exhibit 3)

8. The Appellant also has the following diagnoses: Hepatitis C, foot drop, bursitis, MRSA and cubital tunnel. (Appellant's Testimony)

9. The Appellant takes the following medications: Flexeril, Clonidine, Atropine, Latuda, Gabapentin, Rozerem, Nexium and Ventolin. (Exhibit 3)

10. The Appellant had a hip replacement in 2010. (Appellant's Testimony)

11. The Appellant is Medicaid recipient. (Exhibit 3)

12. The Appellant is [redacted] years (DOB [redacted]) of age. (Exhibit 3)

13. The Appellant lives alone. (Appellant's Testimony)

14. The Appellant has issues with her memory. She avoids cooking with heat because she has forgotten boiling water on the stove. (Appellant's Testimony)

15. The Appellant's hands get numb and painful. She is unable to carry items such as groceries. (Appellant's Testimony)

16. The Appellant requires extensive assistance with one activity of daily living ("ADLs"), dressing. (Exhibit 3)

17. The Appellant uses a shower chair. She requires assistance with getting in and out of the tub. The Department determined that she is independent with bathing. (Exhibit 3)

18. The Appellant is independent with toileting. (Exhibit 3; Appellant's Testimony)

19. The Appellant is independent with transferring. She uses a can for mobility.(Exhibit 3; Appellant's Testimony)

20. The Appellant requires no assistance with eating. She is independent with this ADL. (Exhibit 3; Appellant's Testimony)

21. The PCA reminds the Appellant when she needs to refill and take her medications. She requires oversite and cueing with medication management. (Exhibit 3; Appellant's Testimony)

22. The Appellant is unable to wash dishes, vacuum, or dust. She requires maximal assistance with housework. (Exhibit 3, Appellant's Testimony)

23. The PCA informs the Appellant which bills need to be paid. She requires extensive assistance with managing finances but performs 50% or more of the task on her own. (Exhibit 3; Appellant's Testimony)

24. The Appellant is unable to cut food or cook but can make a sandwich. She requires limited assistance with preparing meals. (Exhibit 3; Appellant's Testimony)

25. The Appellant does not receive physical, occupational or speech therapy. (Appellant's Testimony)

26. On [redacted], 2018, the Department gave the Appellant 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 $41,880.00. The revised budget was reduced to $0.00 for zero hours of PCA hours per week. (Exhibit 2)

27. On [redacted] 2018, the Appellant submitted medical notes from Middlesex Orthopedic Surgeons. (Appellant's Exhibit A: Middlesex Orthopedic Surgeons medical notes)

28. On [redacted] 2018, the Appellant submitted medical notes from InterCommunity. (Exhibit C)

29. On [redacted] 2018, the Appellant submitted medical notes from Manchester Ob-Gyn Associates. (Appellant's Exhibit B: Manchester Ob-Gyn Associates)

30. On [redacted] 2018, the Appellant submitted medical notes from PrimeHealthCare, Pc. (Appellant's Exhibit D: Prime HealthCare, PC notes)

31. On [redacted] 2018, the Department reviewed the Appellant's medical notes and determined that there were no significant changes in the Appellant's activities of daily living status. (Exhibit 8: Department's review of medical notes)

## 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 addresses 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 Appellant requires hands on assistance with dressing and that she is independent with transferring, bathing, toileting and eating.**

**The Department was correct when it determined that the Appellant requires assistance with her IADLs.**

7. 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.

**8. The Department was correct when it determined that the Appellant no longer requires nursing facility level of care.**

9. Connecticut State Plan Amendment ("SPA") no.15-012 (1)(A), pursuant to section 1915(k) of the Social Security Act, provides that the State determines eligibility for Community First Choice (CFC) services in the manner prescribed under 42 CFR § 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 1902(a)(10)(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.

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).

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. Connecticut General Statutes § 17b-259b(b).

**The Department correctly determined that it was not medically necessary for the Appellant to receive community-based long term health services and supports because they are not considered clinically appropriate and effective for her condition.**

## DISCUSSION

CFC is a benefit designed to help individuals remain in the community who would otherwise require institutionalization without the assistance of a PCA. The Appellant has several medical issues and deficits with her IADLs and one ADL. The evidence and testimony provided do not show that she would not be able to remain in the community without the assistance of a PCA. The Department correctly determined that the Appellant does not meet the nursing facility level of care.

## 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.