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

2019
Signature Confirmation

Client ID #
Request #

NOTICE OF DECISION

PARTY

PROCEDURAL BACKGROUND

On , 2019, Connecticut Community Care, Inc. ("CCCI") on behalf of the Department of Social Services (the "Department") issued a Revised CFC Individual Budget notice to (the "participant") reducing the number of service hours under the Personal Care Attendants ("PCA") program from sixty-three (63) hours per week to sixty and three quarters (60.75) hours per week.

On 2019, (the "Appellant") on behalf of the participant requested an administrative hearing to contest the Department's decision to limit service hours under the PCA program to 60.75 hours per week.

On 2019, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for 2019.

On 2019, CCCI, on behalf of the Department, issued a Revised CFC Individual Budget notice to the participant authorizing sixty-three and three quarters (63.75) hours per week under the PCA program.

On 2019, the Appellant requested a continuance which OLCRAH granted.

On 2019, the OLCRAH issued a notice scheduling the administrative hearing for , 2019.

On [redacted], 2019, 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], Appellant
Christine Weston, Department Representative
Sara Denis, Connecticut Community Care, Inc.
Lisa Nyren, Fair Hearing Officer

The record remained open for the submission of additional evidence. On [redacted], 2019, the record closed.

STATEMENT OF THE ISSUE

The issue to be decided is whether the decision to limit PCA services under the Community First Choice ("CFC") program to 63.75 hours per week for the participant was correct.

FINDINGS OF FACT

1. The participant is a recipient of Medicaid under the Husky C program as administered by the Department. (Hearing Record)

2. The participant receives services under the Personal Care Attendant ("PCA") program as administered by the Community First Choice ("CFC"). (Hearing Record)

3. The Appellant is the participant's mother and guardian. (Appellant's Testimony)

4. The participant is age [redacted] born on [redacted]. (Exhibit 1: CT DDS Level of Need Assessment and Screening Tool and Exhibit 2: Universal Assessment)

5. The participant lives at home with the Appellant and his younger sister. (Appellant's Testimony)

6. The participant's medical diagnosis includes: Moyamoya, Stroke, TIA (Trans-Ischemic Attacks), Scoliosis, Macular Degeneration, Depression, and Anxiety/Panic Disorder. (Exhibit 1: CT DDS Level of Need

Assessment and Screening Tool, Exhibit 2: Universal Assessment, Exhibit A: Medical Letters, and Appellant's Testimony)

7. Moyamoya is a rare disorder of the brain blood vessels. Moyamoya is a vascular disease which causes progressive narrowing of the arteries located in the back of the head resulting in a loss of blood to the brain which causes increased occurrences of stroke or TIA's. The participant has had 4 major stroke episodes during his lifetime resulting in hospitalization. (Exhibit A: Medical Letters and Appellant's Testimony)

8. TIA's occur when there is a temporary loss of blood to the brain. TIA's are referred to as mini-strokes. The participant averages 2 TIA's per week. (Appellant's Testimony, Exhibit 1: CT DDS Level of Need Assessment and Screening Tool, Exhibit 2: Universal Assessment, and Exhibit A: Medical Letters)

9. Scoliosis is a curvature of the spine. The participant suffers from a bulging disc and hip misalignment on the right side of his body. The participant walks tilted due to scoliosis, bulging disc, and hip misalignment. The participant has chronic back pain. The participant has right sided body weakness and sensory deficit. (Exhibit 1: CT DDS Level of Need Assessment and Screening Tool, Exhibit 2: Universal Assessment, Exhibit A: Medical Letters and Appellant's Testimony)

10. Macular degeneration is a medical condition which affects the eyes. The participant is legally blind and has limited vision. The participant has peripheral vision loss. (Exhibit 1: CT DDS Level of Need Assessment and Screening Tool, Exhibit 2: Universal Assessment, Exhibit A: Medical Letters, and Appellant's Testimony)

11. The participant participates in physical therapy, aqua therapy, and sees a chiropractor to alleviate back pain. The Appellant rode a special bicycle for exercise until someone stole the bicycle. (Appellant's Testimony)

12. The participant take Baclofen three times per day for back pain, Tylenol 500 mg as needed, baby aspirin daily, multivitamin daily, and Omega 3's daily. (Appellant's Testimony and Exhibit A: Medical Letters)

13. The Appellant administers the participant's medications. (Exhibit 2: Universal Assessment and Appellant's Testimony)

14. The participant requires assistance with activities of daily living ("ADL's") which include: bathing, dressing, eating, hygiene, mobility, and medication management. (Exhibit 1: CT DDS Level of Need Assessment and Screening Tool, Exhibit 2: Universal Assessment, Exhibit A: Medical Letters and Appellant's Testimony)

15. The participant requires assistance when showering. The participant needs assistance when washing his hair and prompting to encourage washing. Due to the risk for strokes or TIA's, safety is a primary concern while showering. CCCI recommends a bath bench, grab bars, and hand-held shower nozzle to assist the participant when bathing. (Exhibit 2: Universal Assessment and Appellant's Testimony)

16. The participant requires assistance when dressing. The participant is able to put on his undergarments, but requires assistance with his shirt, pants, socks, and shoes. The Appellant lays the participant's clothes out daily. Back pain, lack of feeling in his leg and limited vision make dressing on his own difficult and time consuming. (Exhibit 2: Universal Assessment and Appellant's Testimony)

17. The participant requires assistance when eating. The participant requires cuing and reminders. (Exhibit 2: Universal Assessment and Appellant's Testimony)

18. The participant requires support and cuing in order to complete hygiene tasks such as tooth brushing, hair, and hand washing. (Exhibit 2: Universal Assessment and Appellant's Testimony)

19. The participant is able to toilet independently and will not allow assistance. However, the participant's hygiene skills are limited due to both visual and physical limitations. The Appellant must remind the participant to return to the bathroom to follow-through and to ensure proper hygiene. (Exhibit 2: Universal Assessment and Appellant's Testimony)

20. The participant is able to walk on his own, but use of a cane, walker, or wheelchair is recommended. The participant does not like to use his cane or walker. Medicaid has authorized a wheelchair but due to the participant's unwillingness to use his cane or walker, the Appellant has not pursued the purchase of the wheelchair. The participant navigates stairs with support due to limited vision and the risk of stroke. The participant climbs a staircase better than the descent. (Appellant's Testimony and Exhibit 2: Universal Assessment)

21. The participant is able to navigate the home environment due to familiarity. Unfamiliar or changing environments make it difficult for the participant to navigate due to visual limitations and possible obstacles in his path. (Exhibit A: Medical Letters and Appellant's Testimony)

22. The participant is able to transfer from his bed to standing, the couch to standing, and the kitchen chair to standing with support and without time constrictions. Transferring can be time consuming due to limitations

caused by pain. (Exhibit 2: Universal Assessment and Appellant's Testimony)

23. The participant requires assistance with Instrumental Activities of Daily Living which include managing money and home chores. (Appellant's Testimony)

24. The participant manages his money with guidance and support from the Appellant. The participant has a savings account. The participant is able to use an ATM machine with support from his family when he wants to purchase items such as a video game. (Appellant's Testimony)

25. The participant assists with laundry duties, such as folding clothes or towels, as guided by the Appellant. (Appellant's Testimony)

26. The participant plays video games with family and friends. (Appellant's Testimony)

27. The participant requires assistance with meal preparation in the kitchen due to safety concerns, specifically burns from the stove or hot foods. (Appellant's Testimony)

28. On [redacted] [redacted] 2019, CCCI completed an assessment of the participant's benefits under the PCA program using the universal assessment tool. The assessment included observation and contact with the participant, the Appellant, and the participant's sister. (Hearing Record)

29. CCCI is the Department's contractor for completing annual assessments under the PCA program. (Department Representative's Testimony)

30. On [redacted], 2019, CCCI reassessed the participant's budget under the PCA program and reduced the participant's budgeted hours from 63 hours per week previously approved on [redacted] 2018 to 60.75 hours per week of personal care attendants under the PCA program administered by CFC. (Hearing Request)

31. On [redacted] 2019, CCCI issued a Revised CFC Individual Budget notice to the participant. The notice listed the CFC budget as $62,763.66 authorizing 60.75 hours per week under PCA services effective [redacted] [redacted], 2019. (Hearing Request)

32. On [redacted] 2019, the Appellant requested an administrative hearing to contest the reduction of services hours under the PCA program and to contest the limit placed on the service hours. (Hearing Request and Appellant's Testimony)

33. The CFC Unit completed a clinical review of the participant's service hours under the PCA program and determined the participant eligible for 63.75 hours per week under the PCA program. The CFC Unit reviewed the CT DDS Level of Need Assessment and Screening Tool completed by the Department of Developmental Services on , 2018 and the Universal Assessment completed by CCCI on 2019 to make their determination. (Department Representative's Testimony)

34. On 2019, CCCI issued a Revised CFC Individual Budget notice to the participant. The notice listed the CFC budget as $62,763.66 authorizing 63.75 hours per week under PCA services effective , 2019. (Exhibit 3: Revised CFC Individual Budget and Department Representative's Testimony)

35. The participant is eligible for day services from the Department of Developmental Services ("DDS") but is not utilizing such services. The Appellant on behalf of the participant submitted a request to DDS for approval of self-directed day services which include enrollment in college level coursework but has not received a response from DDS. (Department Representative's Testimony and Appellant's Testimony)

36. CFC recommends a physical therapy ("PT") home evaluation to review physical adaptations to the home where the participant resides to ensure the health and safety of the participant in the home. A PT home evaluation is a covered service under Medicaid. The Appellant or the participant makes the request through the participant's physical therapist or physician. (Department Representative's Testimony)

37. CFC will make a referral on behalf of the participant to Intensive Case Management ("ICM") at Community Health Network ("CHN"), the Department's contractor that manages Medicaid benefits, to assist the Appellant on behalf of the participant with locating appropriate general practitioners and specialists and obtaining necessary prior authorizations for medical care. (Department Representative's Testimony)

38. The Appellant is seeking PCA services under the CFC program for twenty-four hours per day on behalf of the participant due to the frequency of the participant's inability to toilet independently during the overnight hours without supervision. (Appellant's Testimony)

39. 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 2019. However, the hearing, which was originally scheduled for 2019, was rescheduled for

[REDACTED] 2019 at the request of the Appellant, which caused a 13-day delay. Because this 13-day delay resulting from the Appellant's request, this decision is not due until [REDACTED] 2019, and therefore timely.

CONCLUSIONS OF LAW

1. Connecticut General Statute ("Conn. Gen. Stats.") § 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 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 of the CFR § 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 (ADL's), instrumental activities of daily living (IADLs), and health related tasks through hands-on assistance, supervision, or cueing.

   Title 42 of the CFR § 441.515(b) provides that states must provide Community First Choice to individuals in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires to lead an independent life.

   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 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.

   Title 42 of the CFR § 441.540(c) provides that the person-centered service plan must be reviewed, and revised upon reassessment of functional

need, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

5. The Department correctly determined the participant 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 participant would otherwise require the level of care furnished in a hospital, a nursing facility, or an intermediate care facility for individuals with intellectual disabilities.

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 support 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.

   Connecticut State Plan Amendment ("SPA") Transmittal No 15-012 effective July 1, 2015 § 1(B) provides that the State determines initially, and at least annually, that individual require the level of care provided in a hospital, nursing facility, an intermediate care facility for individuals with intellectual disabilities (ICF/IID), an institution providing psychiatric services for individuals under 21, or an institution for mental diseases for individuals age 65 and older. The institutional level of care screen is completed by staff of the Department of Social Services on each individual referred to the program. Once an individual successfully completes the screen, the Department refers the individual to contracted entities for

assessment. Staff at contracted entities completes the universal assessment for each individual. The universal assessment confirms institutional level of care and individual level of need.

SPA No 15-012 § 1(C) provides that the Universal Assessment (UA) is a comprehensive and person-centered assessment, surveying the – individual's physical, cognitive, and psychosocial functioning, and identifying risk factors, individual choices, and preferences, and the status of service needs. The UA identifies needs that are met utilizing voluntary natural supports, and state plan and waiver services, thus allowing for a comprehensive assessment, including need for social supports, and services plan. The UA documents each individual's level of need and calculates that individual's budget allocation. Individuals are actively involved in the assessment process and have the opportunity to identify goals, strengths, and needs. Individuals affirm if they would like to identify anyone to participate in the planning process.

SPA No 15-012 § 7 provides in part that the UA is based on the InterRAI tool. The UA is a validation tool used to confirm level of care and calculate a level of need based on the identified needs of the participant. The UA assesses a participant's Activities of Daily living (ADLs) and Instrumental Activities of Daily Living (IADLs) needs as well as taking into account their health, rehabilitation needs, and their natural supports.

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. [Conn. Gen. States. §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. [Conn. Gen. Stats. § 17b-259b(b)]

9. On [redacted] [redacted], 2019, CCCI correctly completed a face-to-face assessment of the participant's physical, cognitive, and psychosocial functioning, needs, strengths, preferences, natural supports, and goals for the services and supports provided under CFC.

10. Title 42 of the CFR § 441.540(a) provides that the person-centered planning process is driven by the individual. The process-

    1. Includes people chosen by the individual.
    2. Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decision.
    3. Is timely and occurs at times and locations of convenience to the individual.
    4. Reflects cultural considerations of the individual.
    5. Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.
    6. Offers choices to the individual regarding the services and supports they receive and from whom.
    7. Includes a method for the individual to request updates to the plan.
    8. Records the alternative home and community-based settings that were considered by the individual.

11. Title 42 of the CFR § 441.540(b) 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:

    1. Reflect that the setting in which the individual resides is chosen by the individual.
    2. Reflect the individual's strengths and preferences.
    3. Reflect clinical and support needs as identified through an assessment of functional need.
    4. Include individually identified goals and desired outcomes.

5. 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.
6. Reflect risk factors and measures in place to minimize them, including individualized backup plans.
7. Be understandable to the individual receiving services and supports, and the individuals important in support him or her.
8. Identify the individual and/or entity responsible for monitoring the plan.
9. Be finalized and agreed to in writing by the individual and signed by all individuals and providers responsible for its implementation.
10. Be distributed to the individual and other people involved in the plan.
11. Incorporate the service plan requirements for the self-directed model with service budget at §441.550, when applicable.
12. Prevent the provision of unnecessary or inappropriate care.
13. Other requirements as determined by the Secretary.

12. Title 42 of the CFR §441.520(a) provides that 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.

    Title 42 of the CFR § 441.505 defines *health-related tasks* as specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals under State law to be performed by an attendant.

13. SPA 15-012 § 5(A) provides for Assistance with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) and health-related tasks through hands-on assistance, supervision, and/or cueing.

    Attendant Care: Services Definition: The State will cover Attendant Care services, which are supports related to core activities of daily living including; physical assistance and/or verbal assistance to the individual in accomplishing any Activities of Daily Living (ADLs), or Instrumental Activities of Daily Living (IADLs). ADLs may include, but not limited to, bathing, dressing, toileting, transferring, and feeding. 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 to participate in the community. In accordance with section 20-101 of the Connecticut General Statute, attendants may complete health maintenance tasks. These tasks may include, but are not limited to, medication administration, wound care, and vital signs under the supervision of the CFC participant.

…

Limits on amount, duration or scope: The Department assigns an overall budget based on need grouping that is determined by algorithm. 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.

…

<u>Environmental Accessibility Adaptations</u>
Service Definition: Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Adaptations meet the requirement under 42 CFR § 441.520(b)(2) which provides for "expenditures relating to a need identified in an individual's person-centered service plan that increases an individual's independence or substitutes for human assistance, to the extent that expenditures would otherwise be made for the human assistance." Such adaptations may include, but are not limited to, the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

Limit on amount and scope: The maximum benefit per individual over a 5 year period is $15,000. This benefit is in addition to the individual budget calculated by the need grouping.

14. Title 42 of the CFR § 441.560(a) provides that for the self-directed model with a service budget, a service budget must be developed and approved by the State based on the assessment of functional need and person-centered service plan and must include all of the following requirements:

    1. The specific dollar amount an individual may use for Community First Choice services and supports.
    2. The procedures for informing an individual of the amount of the service budget before the person-centered service plan is finalized.
    3. The procedures for how an individual may adjust the budget include the following:
        i. The procedures for an individual to freely adjust amounts allocated to specific services and supports within the approved service budget.
        ii. The circumstances, if any, that may require prior approval by the State before a budget adjustment is made.
    4. The circumstances, if any, that may require a change in the person-centered service plan.
    5. The procedures that govern the determination of transition costs and other permissible services and supports as defined at § 441.520(b).
    6. The procedures for an individual to request a fair hearing under Subpart E of this title if an individual's request for a budget adjustment is denied or the amount of the budget is reduced.

15. Title 42 of the CFR § 441.560(b) provides that the budget methodology set forth by the State to determine an individual's services budget amount must:

    1. Be objective and evidence-based utilizing valid, reliable cost data.
    2. Be applied consistently to individuals.
    3. Be included in the State plan.
    4. Include a calculation of the expected cost of Community First Choice services and supports, if those services and supports are not self-directed.
    5. Have a process in place that describes the following:
        i. Any limits the State places on Community First Choice services and supports, and the basis for the limits.
        ii. Any adjustments that are allowed and the basis for the adjustments.

16. Title 42 of the CFR § 441.560(c) provides that the State must have procedures in place that will provide safeguards to individuals when the budgeted service amount is insufficient to meet the individual's needs.

17. Title 42 of the CFR § 441.560(d) provides that the state must have a method of notifying individuals of the amount of any limit that applies to an individual's Community First Choice services and supports. Notice must be communicated in an accessible format, communicated in plain language, and needed auxiliary aids and services should be provided.

18. Title 42 of the CFR § 441.560(e) provides that the budget may not restrict access to other medically necessary care and services furnished under the State plan and approved by the State but which are not included in the budget.

19. Title 42 of the CFR § 441.560(f) provides that the State must have a procedure to adjust a budget when a reassessment indicates a change in an individual's medical condition, functional status, or living situation.

20. CCCI correctly determined the participant requires supports and supervision for a chronic condition requiring substantial assistance on a daily basis.

21. CCCI correctly determined the participant meets the eligibility criteria as established in federal regulations to support the medical necessity for CFC services because the participant's medical condition requires the level of care furnished in a hospital, a nursing facility, or an intermediate care facility.

22. CCCI correctly determined the participant's condition supports the medical necessity for CFC for 63.75 hours per week. CCCI correctly identified the availability of natural supports which include the Appellant, the participant's mother, and the participant's sister who reside in the home both of whom provide paid and unpaid services to the participant. In addition, the participant is eligible for DDS services in which the Appellant has submitted a request for self-directed day services pending DDS' approval of the care plan. Additionally, the Department will refer the participant to the ICM program to access care coordination and care management services available to Medicaid recipients through Community Health Network and the Appellant will request from the participant's physician or physical therapist a review of environmental accessibility adaptations of the home on behalf of the participant. CFC pays for physical adaptations required by the participant's plan of care which ensure the health, welfare and safety of the participant in order to function with greater independence. The hearing record does not reflect the need for additional hours, specifically 24 hours per day, under the CFC.

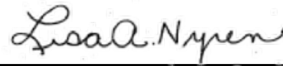
23. On [redacted] 2019, CCCI correctly issued a Revised CFC Individual Budget notice authorizing an annual budget of $62,736.66 equal to 63.75 hours per week under the CFC.

DISCUSSION

Although not discussed at length during the administrative hearing, the participant may benefit from services to support the acquisition, maintenance, and enhancement of skill in order for the individual to accomplish ADLs, IADLs, and health-related tasks. Such services provide teaching strategies and education opportunities for individuals to become more independent in their health-related tasks as outlined under the SPA No 15-012 § 5B.

DECISION

The Appellant's appeal is denied.



Lisa A. Nyren
Fair Hearing Officer

CC: Christine Weston, DSS CO
Dawn Lambert, DSS CO
Sallie Kolreg, DSS CO

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.