STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS,
AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT 06105-3726

[redacted]
Signature Confirmation

Client ID # [redacted]
Request # [redacted]

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted], the Department of Social Services (the "Department") issued a notice of action that it was reducing the Community First Choice ("CFC") budget for [redacted] (the "Recipient") to $25,843.86 or approximately 26.25 hours of attendant care per week.

On [redacted], the Recipient's mother and legal representative (the "Appellant") requested an administrative hearing to contest the Department's decision to reduce such benefits.

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

On [redacted], in accordance with sections 17b-60, 17-61 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] the "Appellant", the Recipient's mother and legal representative
Karri Filek, Public Assistance Consultant, Department of Social Services
Maureen Foley-Roy, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether CFC's determination that 26.25 hours of care per week and corresponding budget is appropriate to meet the Recipient's needs.

FINDINGS OF FACT

1. The Recipient is twenty nine years old and has an intellectual disability. She also had diagnoses of brain injury, seizure disorder and a heart condition. She receives services through the State of Connecticut Department of Developmental Disabilities ("DDS") and she is a recipient of Title 19-Medicaid. (Exhibit 2: DDS Level of Need Assessment and Screening Tool)

2. The Recipient lives with her mother and her siblings, one of whom goes away to college and the other who has multiple sclerosis. The Recipient's mother works outside the home. The Recipient used to spend every other weekend with her father but that has been occurring irregularly recently because he lives with his elderly mother and the mother is becoming frailer. (Exhibit 2 and Appellant's testimony)

3. The Recipient attends the [redacted] day program through DDS, Mondays through Fridays. The Appellant's aid comes to the home from 3 to 7 pm. (Exhibit 4: DDS Person Centered Plan & Appellant's testimony)

4. The CFC program is a Medicaid entitlement program for individuals who meet an institutionalization level of care. It is meant to provide assistance strictly with the activities of daily living ("ADL's) defined at bathing, dressing, eating, toileting and transferring and some health related tasks. CFC provides assistance with any needs with such ADL's that are not being met by DDS or the informal support that she receives naturally, being in the family home. (Department representative's testimony)

5. The CFC program determines eligibility and level of need for budgeting purposes by a universal assessment to assess functional status of ADL's conducted by area agencies. CFC also uses the comprehensive assessment that was conducted by DDS. (Exhibits 5: Universal Assessment dated [redacted], Exhibit 7 pg 3: Universal Assessment Outcome form dated [redacted], Department's summary and Department representative's testimony)

6. In [redacted], CFC allocated a total budget of $37,537.24 for the Recipient. The budget included 37.25 hours a week of Personal Care Assistance ("PCA"), 3 home delivered double meals per week, 4 units of 24 hour PCA coverage annually and 4 units of overnight PCA coverage annually. (Exhibit 6, page 8: CFC budget signed in [redacted])

7. On [redacted], CFC conducted an assessment and revised the CFC budget, reducing it to $24,976.98, effective July 28, 2018. The revised plan eliminated worker's compensation and meal delivery and reduced the PCA hours to 26.25 weekly. (Exhibit 7)

8. On [redacted], the Department advised the agency which provides the Recipient's paid caregivers of her care plan indicating that the budget had been reduced to

$24,976.98. (Exhibit 8: Screen print of Review and Transmit Care Plan to Fiscal Intermediary form)

9. The Recipient's PCA hours were not reduced from the 37.25 hours that had been authorized in the initial assessment and budget. The Appellant continued to submit time sheets for 37.25 hours until she received the [redacted] notice and all providers have been paid. This is a separate issue between the Department and the agency. (Appellant's testimony and Department representative's testimony)

10. In [redacted], DDS conducted a comprehensive needs assessment for the Recipient. The assessment found that the Recipient needed hands on assistance with bathing and grooming, needed prompting, encouraging and reminding for dressing, toileting and eating and was independent with transferring. The assessment found that the Recipient needed assistance with taking medications, using the telephone phone, shopping and meal planning, household chores, budgeting and cooking. The assessment found that the Recipient could not make safe choices at home or out in the community. She cannot safely cross the street or respond appropriately to strangers. She is at risk of being taken advantage sexually and financially. She cannot use cell phone, internet or electronic devices appropriately. She exhibits disruptive behaviors, such as verbal aggression and opposes support and assistance. She has wandered away. (Exhibit 2)

11. The Recipient was taken advantage sexually by a known acquaintance. She cannot use a knife and is unaware of the dangers presented with using the microwave because she has a pacemaker. (Appellant's testimony)

12. On [redacted], CFC conducted another assessment, which determined that the Recipient was eligible for 26.25 hours of personal care assistance every week. The assessment determined that the Recipient needed extensive assistance with bathing, dressing and toileting and was independent with transferring and eating.(Exhibit 5)

13. On [redacted], CFC issued a notice service budget reduction advising that the Recipient's budget had been revised to $25,843.86, approximately 26.25 hours per week. (Exhibit 5)

14. The Appellant has been limiting the PCA hours to 26.25 weekly since receiving the notice and has been finding it difficult to manage with the reduced hours. She works outside the home and assists in the care of an autistic grand-nephew as well as caring for her other daughter who has MS. (Appellant's testimony)

15. The reduction in hours makes it difficult for the Recipient to attend functions in the community, dances and social activities. (Appellant's testimony)

16. After considering the services that the Recipient receives through DDS and the informal supports naturally provided by her family, CFC determined that the Recipient has unmet needs in the areas of bathing, dressing and toileting. CFC determined that

the Recipient was in need of an additional 26.25 hours of assistance each week to meet those needs. (Department representative's testimony)

17. 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 [redacted]. Therefore, this decision was due not later than [redacted] and is timely.

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") § 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 § 441.510 provides in part 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 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.

   Title 42 CFR § 441.520 (a) provides that If a State elects to provide Community First Choice, the State must provide all of the following services: assistance with ADLs, IADLs, and health-related tasks through hands-on assistance, supervision, and/or cueing, acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks, backup systems or mechanisms to ensure continuity of services and supports, as defined in § 441.505 of this subpart and voluntary training on how to select, manage and dismiss attendants.

   Title 42 CFR § 441.505 provides for the definition of the Activities of Daily Living ("ADLs") and states that ADLs means basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and

transferring.

The Department was correct when it determined that the Recipient needed extensive assistance with bathing, dressing and toileting (3 ADLs).

4. Title 42 CFR§ 441.505 also provides for the definition of Instrumental Activities of Daily Living ("IADLs") and states that 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 median and traveling around and participating in the community.

   The Department was correct when it determined that the Recipient needed assistance with all of her IADL's.

5. 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.

   Connecticut State Plan Amendment ("SPA") no.15-012, pursuant to section 1915(k) of the Social Security Act, 5 A 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 mother and siblings are a source of natural support for her ADLs and IADLs.

6. 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. Stat. § 17b- 259b (a).

The Department was correct when it determined that the Recipient has been awarded assistance from DDS to provide socialization and prepare the Recipient for work activities and other IADL's. The day program provided through DDS, along with the 26.25 hours weekly approved for CFC services, and the natural supports from her family do not place the Recipient at risk of institutionalization.

Based on the evidence provided, the reduction in the Recipient's weekly PCA hours to 26.25 hours per week is adequate to meet the Recipient's functional needs with regards to her medical condition and overall health; therefore, the Department was correct when it determined that additional hours of PCA through CFC services are not medically necessary for the Recipient because the type, frequency and duration of such services are not clinically appropriate, at this time, given the other services and natural supports that are currently in place.

DISCUSSION

The undersigned acknowledges the difficulty of the totality of the Appellant's situation. The Appellant had received help in the past from the Recipient's father and grandmother which is now diminishing due to the grandmother's advanced age. In addition to the Recipient's needs, she also cares for another child with MS and assists in the care of a young relative with autism. The issue of this hearing is limited to the CFC benefits for the Recipient.

Community First Choice is a benefit available to Medicaid recipients under the State Plan to provide services in home to individuals who would be otherwise require institutionalization as determined by state standards. The hearing summary and testimony at the hearing indicated that additional benefits (in hours) are not medically necessary because the Recipient receives necessary services through the DDS waiver and natural supports from her family.

The Appellant's concern is that the reduction in hours will mean that the Recipient will be unable to participate in social activities. DDS has responsibility for the Recipient's needs regarding her IADL's and socialization. CFC has budgeted for needs related to her ADL's and medical necessity. Given the Recipient's current needs and the assistance provided by DDS and her natural supports, additional hours beyond the 26.25 are not medically necessary.

DECISION

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

Maureen Foley-Roy
Hearing Officer

PC: Dawn Lambert, DSS, Community First Choice Program
Sallie Kolreg, DSS, C. O.
Lisa Bonetti, DSS, C. O
Karri Filek, DSS

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 06105-3730.

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.