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

[REDACTED] 2019
Signature Confirmation

Case # [REDACTED]
Client ID # [REDACTED]
Request # 145407

NOTICE OF DECISION

PARTY

[REDACTED]

PROCEDURAL BACKGROUND

On [REDACTED] 2019, the Department of Social Services (the "Department") issued a verbal notice of action to [REDACTED] (the "Appellant") denying her request for Personal Care Attendant ("PCA") services through the Community First Choice ("CFC") program due to not meeting the institutional level of care criteria.

On [REDACTED] 2019, the Appellant requested an administrative hearing to contest the Department's denial of her application for CFC services.

On [REDACTED] 2019, the Department issued a written notice of action to the Appellant denying her request for PCA services through the CFC program due to not meeting the institutional level of care criteria.

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

On [REDACTED] 2019, in accordance with sections 17b-60, 17b-61, and 4-176e to 4-184, inclusive, of the Connecticut General Statutes, OLCRAH held an administrative hearing.

The following individuals were present at the hearing:

[redacted], Appellant
Alba Peguero, Interpreter, ITI Translates
Randell Wilson, Supervisor at Connecticut Community Cares
Garfield White, Department's Proctor
Karri Filek, CFC Representative, DSS Central Office
Christopher Turner, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department correctly denied the Appellant's CFC application for PCA services.

FINDINGS OF FACT

1. On [redacted] 2019, the Appellant participated in a comprehensive Universal Assessment with Donna Grieder from Connecticut Community Cares for a review of Medicaid long-term care supports and services. The assessment included an evaluation of the Appellant's physical status, mental status, and functional abilities, and consideration of the Appellant's Activities of Daily Living ("ADLs"), Instrumental Activities of Daily Living ("IADL's"), and health-related tasks at home. (Exhibit 3: Universal Assessment; Hearing summary)

2. On [redacted] 2019, the Department verbally advised the Appellant it was denying her request for CFC services because she does not meet the institutional level of care criteria. (Record)

3. On [redacted] 2019, the Department issued the Appellant a notice of action denying her request for PCA services through the CFC program due to the Appellant not meeting the level of care criteria as defined in 42 U.S.C. § 1396n(K)(1) and 42 C.F.R. § 441.510(c). (Record)

4. The Appellant is [redacted] and a Medicaid recipient. (Record; Appellant's testimony)

5. The Appellant resides with her son. (Appellant's testimony)

6. The Appellant requests CFC benefits in order to obtain assistance with her ADL's and IADL's. (Exhibit 3; Appellant's testimony)

7. Connecticut Community Cares is the Department's contractor for assessing level of care and service needs for CFC benefits. (Record; Hearing summary)

8. The Appellant is receiving treatment for Osteoarthritis and Neuropathy. (Exhibit 3; Hearing summary)

9. The Appellant has been diagnosed with end-stage renal disease, and lumbar disease. (Exhibit 3; Hearing summary)

10. The Appellant has been diagnosed with Asthma, Cardiac arrhythmia, Hypertension, Depression and Anxiety, Hyperthyroid, Diabetes type 2. (Exhibit 3)

11. The Appellant has been diagnosed with Gastroesophageal disease, Acid reflux, Anemia. (Exhibit 3)

12. The Appellant has not been hospitalized within the last 90 days from ████19. (Exhibit 3)

13. The Appellant has visited the doctor's office ██ times within the last ██ days from the date of assessment. (Exhibit 3)

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

15. The Appellant takes the following medications: Albuterol, Montelukast, Pro Air, Lodatine, Losartan, Synthroid, Chlorthalidone, Sulfate ferroso, Gabapentin, Baclofen, Oxycodone, Cymbalta, Omeprazole, and Metformin. (Exhibit 3; Appellant's testimony)

16. The Appellant was found to be independent with the following ADL's: toileting, transferring and eating but requiring extensive assistance with bathing and dressing. (Exhibit 3; Appellant's testimony)

17. The Appellant was found to be independent with the following IADL's: medication administration and setup, managing finances, communicating by phone or other media, and traveling around and participating in the community but requiring assistance with completing household chores, shopping and meal preparation. (Exhibit 3)

18. The Appellant does not require hands-on or direct care from a nurse on a daily basis. (Exhibit 3)

19. The Appellant receives home health care services from ████████████ Monday through Friday for one and a half hours. Title 19 pays for the Appellant's home care services. (Exhibit 3; Appellant's testimony)

20. The Appellant's son provides unpaid voluntary assistance on behalf of the Appellant. The Appellant's son provides his mother with informal help for some ADL's and IADL's. (Exhibit 3; Appellant's testimony)

21. The Appellant has and uses a shower chair with help from her home health aide (Exhibit 3; Appellant's testimony)

22. The Appellant has and uses a cane for mobility; she has a walker with a seat and without a seat. (Exhibit 3; Appellant's testimony)

23. The Appellant is not at risk for homelessness. (Exhibit 3; Appellant's testimony)

24. The Appellant lives on the third floor of a building that has an elevator. At times, the elevator is not working which poses a problem for the Appellant in regards to climbing stairs and entering and leaving her apartment. (Exhibit 3; Appellant's testimony)

25. The Appellant utilizes the Department's Medicaid transportation provider VEYO to get to her medical appointments. (Exhibit 3; Appellant's testimony)

26. The evidence in the hearing record to ascertain whether PCA services are necessary for the Appellant to address unmet activities of daily living is comprehensive in nature. (Record)

27. The issuance of this decision is timely under Connecticut General Statutes 17b-61(a), which requires that a decision be rendered within 90 days of the request for an administrative hearing. The Appellant requested an administrative hearing on ████████ 2019. This decision, therefore, was due no later than ██████████, 2019. (Hearing Record)

CONCLUSIONS OF LAW

1. Connecticut General Statutes ("Conn. Gen. Stat.") § 17b-2 provides that the Department of Social Services is designated as the state agency for the administration of (6) the Medicaid program pursuant to Title XIX of the Social Security Act.

2. Title 42 of the Code of Federal Regulations ("C.F.R.") 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. (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.

3. 42 C.F.R. § 441.535 provides for the 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 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.

The Department was correct when it assessed the Appellant’s needs.

4. 42 C.F.R. § 441.505 defines activities of daily living (“ADL’s”) 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 Appellant requires extensive assistance with bathing and dressing.

5. 42 C.F.R. § 441.505 defines instrumental activities of daily living (“IADL’s”) 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 assistance with completing household chores, shopping and meal preparation.

6. 42 C.F.R. § 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: (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; (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 United States Code § 1396n(c)(1) provides in relevant part the Secretary may by waiver provide that a State plan approved under this subchapter may include as “medical assistance” under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan.

42 C.F.R. § 441.520 provides for included services. (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.

The Department correctly determined that the Appellant is not at risk of being institutionalized.

The Department correctly determined the Appellant does not meet the Level of Care criteria needed in order to receive CFC services.

7. Conn. Gen. Stat. §17b-259b defines medically necessary and medical necessity. (a) provides 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 State Plan Amendment no.15-012 (5)(A), pursuant to section 1915(k) of the Social Security Act, provides for limits on the 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 correctly determined that the Appellant's son is a source of natural support for her ADL's and IADL's.

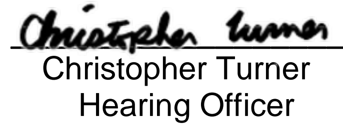
   The Department correctly determined PCA services are not medically necessary for the Appellant to meet her functional needs because the type, frequency, and duration of such services are not clinically appropriate at this time given that other services and natural supports are currently in place.

DISCUSSION

The testimony offered by the Appellant to establish the need for a PCA was not compelling in nature and the evidence presented does not substantiate or demonstrate the need for PCA services through CFC.

DECISION

The Appellant's appeal is denied.



Christopher Turner
Hearing Officer

Cc: hearings.commops@ct.gov
Karri Filek, Department of Social Services, 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, law, and 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 the 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 if 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.