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

[redacted], 2025
Signature Confirmation

[redacted]
[redacted]
Request # 254055

NOTICE OF DECISION

PARTY

[redacted]
[redacted]
[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2024, the Department of Social Services (the "Department") issued a Notice of Action ("NOA") to [redacted] (the "Appellant") reducing the recipient's Community First Choice ("CFC") Individual Budget from $70,621.82 to $39,605.58 annually and reducing her primary care attendant ("PCA") hours from 52 to 26.25 hours weekly effective [redacted] 2025.

On [redacted] 2025, [redacted], (the "Guardian") the Appellant's Guardian requested an administrative hearing to contest the Department's budget reduction.

On [redacted], 2025, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2025.

On [redacted] 2025, 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 participated in the hearing:

[redacted], Appellant
[redacted] Appellant's Guardian
[redacted], Interpreter, [redacted]

Glenn Guerrera, Department of Social Services (the "Department") Observing Representative
Clarissa James, CFC Assessor, CT Community Care, Community First Choice
Janette Steward, Nurse Consultant, Department of Social Services
Cynthia Cartier, Legal Counsel, Department of Social Services
Carla Hardy, Hearing Officer

The hearing decision will be translated into [redacted] and mailed to the Appellant at a later date.

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department correctly reduced the Appellant's CFC service budget based on a reassessment of the Appellant's level of need.

FINDINGS OF FACT

1. The Appellant is 27 years old (DOB [redacted]/1997) and resides in the community with her mother. The Appellant is a Medicaid recipient and was previously granted services under the CFC program. (Hearing Record)

2. [redacted] (the "Guardian") is the Appellant's Guardian and mother. She is the Appellant's personal care assistant ("PCA"). (Guardian's Testimony)

3. On [redacted] 2024, the Appellant participated in an annual face-to-face reassessment conducted by Clarissa James ("CFC Assessor"), the CFC Assessor with Connecticut Community Care ("CCC"). The CFC Assessor documented that the Appellant required extensive assistance with three of her five activities of daily living ("ADLs"). She required extensive assistance with bathing, dressing, and toileting. She was independent with transferring and required cueing with eating. (Exhibit 2: Universal Assessment Outcome Care Plan)

4. CCC is the Department's contractor that assesses the level of care and service needs for the CFC program. (Hearing Record)

5. The Appellant is non-verbal and diagnosed with Scoliosis, Asthma, COPD, Anxiety, Lyme Disease, GERD, Cerebral Palsy, Anemia, and Intellectual Disability (unspecified). (Exhibit 2, Guardian's Testimony, Hearing Record)

6. The Appellant accesses her CFC benefits for instrumental activities of daily living ("IADLs") through the Department of Developmental Services ("DDS"). DDS acts as a Medicaid operating partner under a Memo of Understanding with the Department. (Hearing Record)

7. The Appellant has been active on the DDS Waiver program since she was 21 years old. (Guardian's Testimony)

8. Because the Appellant is active with DDS, she is eligible and required to receive services through that department. (Hearing Record)

9. The Appellant's IADLs will be covered by DDS. Her hands-on needs or ADLs will be covered by CFC. (Nurse Consultant's Testimony, Hearing Record)

10. The Appellant receives case management and other supportive services under the DDS waiver. Those services will lead to the acquisition, improvement, and/or retention of skills and abilities to prepare the Appellant for work, community participation, socialization, leisure, and retirement activities. (Exhibit 3: DDS Lovel of Need ("LON") [redacted]/24, Hearing Record)

11. The Appellant is eligible to receive PCA hours for three ADLs. One ADL is equal to 8.75 hours. Her three ADLs that require extensive assistance translate to 26.25 (8.75 x 3 = 26.25) hours weekly and a yearly budget of $39,795.21. (Exhibit 2: Universal Assessment Care Plan, Exhibit 4: Budget Memo)

12. The Appellant requires extensive assistance with bathing, dressing, and toileting. (Guardian's Testimony)

13. The Appellant is independent with transferring but needs someone to remind her to eat more slowly. (Guardian's Testimony)

14. The Appellant's prior budget afforded her 52 hours in PCA hours weekly. Since the Appellant is on the DDS waiver, that program will provide the Appellant with behavioral and IADL needs. (Hearing Record)

15. The Appellant's DDS hours have increased due to the reduction in the Appellant's CFC hours. (Department's Legal Counsel's Testimony)

16. On [redacted] 2024, 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 $70,621.82. The new revised annual budget was reduced to $39,605.58 which is equal to 26.25 hours of PCA services weekly effective [redacted] 2025. (Exhibit 1: Notice of Action, [redacted]24)

17. On [redacted] 2025, the CFC budget was revised from $39,605.58 to $39,795.21. (Exhibit 2)

18. 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] 2025; therefore, this decision is not due until [redacted] 2025. (Hearing Record)

CONCLUSIONS OF LAW

1. Section 17b-2 of the Connecticut General Statutes ("Conn. Gen. Stat.") 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.

   Conn. Gen. Stat. § 17b-260 provides that the Commissioner of Social Services is authorized to take advantage of the medical assistance programs provided in Title XIX, entitled "Grants to States for Medical Assistance Programs", contained in the Social Security Amendments of 1965 and may administer the same in accordance with the requirements provided therein, including the waiving, with respect to the amount paid for medical care, of provisions concerning recovery from beneficiaries or their estates, charges and recoveries against legally liable relatives, and liens against property of beneficiaries.

   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.

   The Department has the authority to administer and determine eligibility for the Medicaid program and related State Plan Options including the CFC program.

2. Title 42 C.F.R. § 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 (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands-on assistance, supervision, or cueing.

   Title 42 C.F.R. § 441.505 provides for definitions and states in relevant 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.

3. Title 42 C.F.R. § 441.510 addresses eligibility. 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 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.

4. Title 42 C.F.R. § 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.

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.

Title 42 C.F.R. § 441.540(c) provides for reviewing the person-centered service plan. 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.

SPA No 15-012 § 1(B) provides that the State determines initially, and at least annually, that individuals 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 aged 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.

The Department correctly determined the Appellant is subject to an annual review to establish, that in the absence of the home and community-based attendant services and supports provided by the CFC program, the Appellant would require the level of care furnished in a hospital, a nursing facility, or an intermediate care facility for individuals with intellectual disabilities.

The Department correctly completed an in-person 12-month review with the Appellant on [redacted] 2024.

5. Conn. Gen. Stat. § 17b-259b(a) 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.

6. State Plan Amendment (“SPA”) no. 15-012 § 1(A) provides in relevant part that individuals who are receiving medical assistance under the special home and

community-based waiver eligibility group defined in 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.

SPA no. 15-012 § 5(A) provides in relevant part 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. 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.

Based on the evidence provided, the reduction in the Appellant's CFC budget from $70,621.82 yearly to $39,605.58 or 26.25 hours per week is sufficient to meet the Appellant's needs. The Department correctly determined additional PCA hours in conjunction with the DDS hours are not medically necessary for the Appellant to meet her needs.

7. Title 42 C.F.R. § 441.560(d) provides 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. The notice must be communicated in an accessible format, communicated in plain language, and needed auxiliary aids and services should be provided.

On [redacted] 2024, the Department properly issued the Appellant a Community First Choice Program Service Budget Reduction notice informing her that her CFC budget and PCA hours have been reduced

effective [redacted] 2025.

DECISION

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

Carla Hardy
Carla Hardy
Hearing Officer

Pc: Community Options, Department of Social Services, Central Office
Randell Wilson, Manager, Department of Social Services, Central Office
Cynthia Cartier, JD, LLM, Staff Counsel, 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 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, 165 Capitol Avenue, 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.