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

[redacted] **2025**
Signature Confirmation

[redacted]
[redacted]
Request #: 255228

NOTICE OF DECISION

PARTY

[redacted]
[redacted]
[redacted]
[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2025, the Department of Social Services (the "Department") sent [redacted] ("the "Appellant") a Notice of Action ("NOA") reducing the number of Person Care Attendant ("PCA") service hours under the Community First Choice ("CFC") program from 40.00 to 21.50.

On [redacted] 2025, the Appellant requested an administrative hearing to contest the Department's decision to reduce his CFC budget and PCA service hours.

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, 17-61 and 4-176e to 4-184 inclusive, of the Connecticut General Statutes, OLCRAH held a telephonic administrative hearing.

The following individuals participated:

[redacted], Appellant
[redacted], Appellant's Spouse
[redacted], Appellant's Daughter and caretaker
[redacted] Appellant's Son-in-law
Nicole, Language Link Interpreter #20438

Attorney Cynthia Cartier, Department Legal Counsel
Janette Steward, Department's Representative, CFC Nurse Consultant
Mayra Davis, CFC Supervisor, Agency of Aging of South-Central CT ("AOASCC")
Alina Alexander, CFC Assessor, AOASCC

STATEMENT OF THE ISSUE

The issue is whether the Department correctly reduced the Appellant's CFC service budget and PCA service hours under the CFC program to 21.50 hours per week effective [redacted] 2025.

FINDINGS OF FACT

1. The Appellant is a [redacted]-year-old [Date of Birth: [redacted] recipient of Medicaid and resides in the community with his spouse, [redacted] *(Department's Testimony; Exhibit 2: CFC 2024 Budget & Care Plan)*

2. The Appellant receives PCA support services through the CFC program for his Activities of Daily Living ("ADL's"), Instrumental Activities of Daily Living ("IADL's") and health related tasks. The CFC program provides services to keep the Appellant in the community, where he would otherwise require nursing home placement. A budget is provided to the Appellant based on a Universal Assessment ("UA"), and he chooses his care providers. The Appellant's daughter provides care for the Appellant. *(Hearing Record; Daughter's Testimony)*

3. The Appellant has the primary diagnosis of type 2 diabetes with the following contributing diagnoses: gout, osteoarthritis, hypertension, asthma, and sleep apnea. *(Hearing Record; Exhibit 2; Exhibit 3: CFC 2023 Budget)*

4. On [redacted] 2024, a worker from the AOASCC, the Department's contractor that assesses the level of care and service needs for CFC, completed a face-to-face assessment with the Appellant. The comprehensive assessment included the following: (1) evaluation of physical status; (2) evaluation of mental status, and (3) functional assessment. The worker assessed the Appellant's ADL's, IADL's and all health-related tasks and determined he requires limited assistance with bathing, dressing, toileting, and transferring and was independent with eating. The Appellant requires extensive, max assistance or total dependence with zero (0) ADL's. The worker determined the Appellant's Level of Need ("LON") as three (3). *(Hearing Record; Exhibit 2)*

5. CFC uses the following chart to determine the number of hours and budget based on the Level of Need ("LON"):

LON	Hours of PCA per week	Monthly Budget	Annual Budget
1	13.00	$1,634.52	$19,614.19

2	17.00	$2,137.44	$25,649.33
3	**21.50**	**$2,703.24**	**$32,438.86**
4	23.50	$2,954.70	$35,456.42
5	25.75	$3,237.60	$38,851.19
6	28.75	$3,614.80	$43,377.54

(Department's Testimony; Exhibit 4: CFC Budget Categories)

6. The Appellant meets the LON of three (3) and qualifies for 21.50 PCA hours per week and has a budget of $32,438.86. The Appellant scored moderate on the cognition portion of the UA which is considered when determining the LON score. The Appellant was receiving an exception of 40 hours at his last assessment based on medical reports. His need for extensive assistance with transferring has improved, and is no longer receiving an exception, thus resulting in a decrease in PCA hours. *(Department's Testimony; CFC Assessor's Testimony; Exhibit 2; Exhibit 4)*

7. The Appellant uses a cane and wheelchair as assistive devices for mobility and to decrease his fall risk. His PCA assists with cooking, shopping, making appointments and transporting him to appointments, grooming, dressing, bathing and medication management. The Appellant's daughter reports her father is weaker, his vision is worse, he is forgetting things and requires more assistance. The Appellant takes both oral and injection medications which are administered by his daughter/PCA. The medications are taken either once or twice per day. *(Appellant's Daughters Testimony)*

8. On [redacted] 2025, the Department issued the Appellant a NOA stating a service budget reduction. The notice informed the Appellant that his revised individual budget will be $32,594.17 effective [redacted] 2025. The notice states the budget amount equals about 21.50 hours of PCA per week. *(Department's Testimony; Exhibit 5: NOA)*

9. On [redacted] 2025, the Appellant requested an administrative hearing and is seeking to remain at or increase his PCA service hours from the CFC program. The Appellant indicates a need for increased hours to have the PCA monitor and assist with bathing, bathroom, dressing, etc. *(Hearing Record; Appellant's Testimony)*

10. The issuance of this decision is timely under Connecticut General Statutes section 17b-61(a), which requires the agency to issue a decision within 90 days of the request for an administrative hearing. The Appellant requested an administrative hearing on [redacted] 2025; therefore, this decision is due no later than [redacted] 2025.

CONCLUSIONS OF LAW

1. Section 17b-2 of the Connecticut General Statues provides 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.

Title 42 of the Code of Federal Regulations (“C.F.R.”) Section 441.500(a) provides that this subpart implements section 19415(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.

42 C.F.R. § 441.500 provides for basis and scope and states (a) Basis. 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) Scope**.** 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.

42 C.F.R. § 441.515 provides that States must provide Community First Choice to individuals: (a) on a statewide basis. (b) 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.

The Department has the authority to administer the CFC program.

2. 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, and transferring. Instrumental activities of daily living (IADLs) mean 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 media, and traveling around and participating in the community.

   Connecticut State Plan Amendment (“SPA”) No. 15-012, pursuant to section 1915(k) of the Social Security Act, effective July 1, 2015, § 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.

The Department correctly determined that the Appellant requires extensive, max, or total dependence with zero (0) ADL's.

3. 42 C.F.R. § 441.510 provides for eligibility and states 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.

CT SPA No. 15-012 § 1(B) provides 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 age 65 or 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 complete 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 meets the criteria for the CFC program and is subject to an annual review to reassess the Appellant's functional need and care level.

4. 42 C.F.R. § 441.520 provides for included services and states as follows:
   (a) If a State elects to provide Community First Choice, the State must provide all of the following services:
      (1) Assistance with ADLs, IADLs, and health-related tasks through hands-on assistance, supervision, and/or cueing.
      (2) Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks.
      (3) Backup systems or mechanisms to ensure continuity of services and supports, as defined in § 441.505 of this subpart.
      (4) Voluntary training on how to select, manage and dismiss attendants.
   (b) At the State's option, the State may provide permissible services and supports that are linked to an assessed need or goal in the individual's person-centered service plan. Permissible services and supports may include, but are not limited to, the following:
      (1) Expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities linked to an assessed need for an individual to transition from a nursing facility, institution for mental diseases, or intermediate care facility for Individuals with Intellectual Disabilities to a home and community-based setting where the individual resides;
      (2) 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.

CT SPA No. 15-012 § 5 provides for included services: required services & permissible purchases for attendant care and states 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.

The Appellant lives with his spouse and utilizes his daughter as his caretaker. The Appellant's son-in-law provides care for his spouse.

5. 42 C.F.R. § 441.535 provides for assessment of functional need and states 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.

   CT SPA No. 15-012 § 1(C) provides 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 service 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.

   The Department correctly completed a face-to-face assessment of the Appellant's needs, strengths, preferences, and goals.

6. 42 C.F.R. § 441.540(b)(5) provides for person-centered service plan and states 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.

42 C.F.R. § 441.540(c) provides for reviewing the person-centered service plan and states the State must ensure that the person-centered service plan for every individual is reviewed, and revised as appropriate, based upon the 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. States must adhere to the requirements of § 441.301(c)(3), except that the references to section 1915(c) of the Act are instead references to section 1915(k) of the Act.

7. 42 C.F.R. § 441.560(b) provides for service budget requirements and states the budget methodology set forth by the State to determine an individual's service 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.

   CT SPA No. 15-012 § 5(A) provides for limits on amount, duration or scope and states 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.

   The Department correctly determined that the participant requires supports and services of 21.50 hours per week based on the Appellant's [redacted] 2024, annual UA.

   The Department correctly determined that the 21.50 hours are sufficient to meet the Appellant's needs based on his LON score of three (3) and not requiring extensive or greater assistance with any ADL's.

8. 42 C.F.R. § 441.560(f) provides 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.

CT SPA No. 15-012 § 1(C) provides in relevant part the individual may be assessed more frequently if his or her functional needs change or if he or she or an authorized representative of the individual so requests.

9. 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. Notice must be communicated in an accessible format, communicated in plain language, and needed auxiliary aids and services should be provided.

   On [redacted] 2025, the CFC correctly issued a NOA, Service Budget Reduction letter to the Appellant informing that his CFC budget and service hours have been reduced. The notice indicates an annual budget of $32,594.17 equal to 21.50 hours per week under the CFC, effective [redacted] 2025.

DECISION

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

Amy MacDonough
Fair Hearing Officer

CC: hearing.commops@ct.gov
Cynthia Cartier, Staff Counsel, OLCRAH, Central Office
Randell Wilson, Program Manager, DSS, Community Options

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.