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

CASE # [redacted]
CLIENT# [redacted]
REQUEST# 257627

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted], 2025, the Department of Social Services (the "Department") sent [redacted] (the "Appellant"), a Notice of Action ("NOA") stating that it was revising his Community First Choice ("CFC") budget from $109,386.84 per year to $66,325.35 per year, equaling 43.75 hours of Personal Care Assistant ("PCA") per week, effective [redacted] 2025.

On [redacted] 2025, the Appellant requested an administrative hearing to contest the Department's determination of the amount of PCA 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, the OLCRAH issued a notice rescheduling the administrative hearing, at the Appellant's request, 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, OLCRAH held an in-person administrative hearing. The following individuals participated in the hearing:

[redacted], Appellant's Guardian

Janette Steward, Nurse Consultant, CFC, Department's Representative
Cynthia Cartier, Staff Counsel, Department's Representative
Mayra Davis, Supervisor, Agency on Aging South Central Connecticut
Melissa Prisavage, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department correctly revised the Appellant's CFC service budget to $66,325.35 per year and 43.75 hours per week based on an assessment of his level of need.

FINDINGS OF FACT

1. The Appellant is a recipient of the Medicaid program and has been granted services under the Community First Choice ("CFC") program to provide support for his Activities of Daily Living ("ADLs") and health related tasks. (Hearing Record, Department's Testimony)

2. Effective [redacted], 2025, the Department approved the Appellant for an annual budget of $66,325.35 equaling 43.75 hours per week of PCA services under the CFC program. (Exhibit 2: NOA, dated [redacted], 2025, Exhibit 4: Universal Assessment Outcome, dated [redacted], 2025, Exhibit 5: Budget Categories Charts)

3. The Appellant is [redacted]-years-old [DOB [redacted]] and has diagnoses of cerebral palsy, scoliosis, and an intellectual disability. (Hearing Record, Exhibit 1: DDS Level of Need Assessment)

4. The Appellant resides at home with his family. (Hearing Record)

5. The Appellant utilizes Personal Care Assistants ("PCAs") to assist with his ADLs. (Hearing Record)

6. The Appellant accesses his CFC services through the Department of Developmental Services ("DDS") waiver. (Hearing Record)

7. On [redacted], 2025, the Department, under the CFC program, finalized an annual assessment to evaluate the child's ADL needs. (Hearing Record)

8. The Universal Assessment was conducted face to face by a social worker with Agency on Aging of South Central Connecticut ("AASCC"), the Department's contractor for the purpose of assessing level of care and service needs for CFC services. (Hearing Record)

9. The Universal Assessment Outcome reflects that the Appellant needs extensive assistance with eating. (Hearing Record)

10. The Universal Assessment Outcome reflects that the Appellant needs max assistance with bathing, dressing, and toileting. (Hearing Record)

11. The Universal Assessment Outcome reflects that the Appellant needs total dependence with transferring. (Hearing Record)

12. A clinical nurse at the Department reviewed the comprehensive assessment of needs, including the detailed assessment of core ADLs, and determined that the appropriate level of support for the Appellant is 43.75 hours per week to maintain him in the community. (Hearing Record)

13. The CFC program only covers ADLs, as the Appellant is on a DDS waiver and receives services for his Instrumental Activities of Daily Living ("IADLs") and behavioral needs through the DDS waiver. (Hearing Record, Department's Testimony)

14. On [redacted], 2025, the Department hand delivered a Notice of Action to the Appellant revising his CFC individual budget from $109,386.84 to $66,325.35 yearly, representing 43.75 hours per week of PCA services effective [redacted], 2025. (Exhibit 2)

15. The issuance of this decision is timely under section 17b-61(a) of Connecticut General Statutes, 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. There were 35 delay days added due to the rescheduling of the hearing. Therefore, this decision is due no later than [redacted] 2025. (Hearing Record)

CONCLUSIONS OF LAW

1. Section 17b-2 of the Connecticut General Statutes ("Conn. Gen. Stat.") authorizes the Commissioner of the Department of Social Services to administer the Medicaid program.

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.

3. 42 C.F.R. § 441.500(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.

4. 42 C.F.R. § 441.505 provides for definitions and states in 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.

The Department was correct when it determined that the Appellant requires extensive assistance with eating, max assistance with bathing, dressing, and toileting, and total dependence with transferring.

5. 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 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.

6. 42 C.F.R. § 441.520 provides for included services 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.

7. 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.

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

8. 42 C.F.R. § 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.

9. Connecticut State Plan Amendment ("SPA") no.15-012 (5)(A), pursuant to section 1915(k) of the Social Security Act, 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 Appellant's family is a source of natural support for his ADLs.

10. 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 General Statutes § 17b-259b(a).

    The Department correctly determined that the 43.75 weekly hours of services provided through CFC with the natural supports provided by the Appellant's family along with services provided to him through the DDS waiver do not place the Appellant at risk of institutionalization.

    Based on the evidence provided, the reduction in the Appellant's PCA budget from $109,386.84 to $66,325.35 yearly is sufficient to meet the Appellant's needs.

DISCUSSION

Although there was a discrepancy between the budget dollar amount on the Notice of Action and the dollar amount listed on the budget chart, the Department testified that there was an increase in wages for the PCAs which accounted for this, but there was no effect on the number of hours. There was also a discrepancy between the hearing record and the Universal Assessment Outcome regarding the level of need for transferring. However, this would not make a difference to the number of hours for which the Appellant is eligible, as he is eligible for hours based on meeting the level of need for all 5 ADLs.

DECISION

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

Melissa Prisavage

Melissa Prisavage
Fair Hearing Officer

CC: hearings.commops@ct.gov
Cynthia Cartier, Staff Counsel, Central Office
Randell Wilson, Manager, CFC, 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.