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

[redacted] 2024
Signature Confirmation

Case # [redacted]
Client ID # [redacted]
Request # [redacted]

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2024, the Department of Social Services (the "Department") notified [redacted] (the "Appellant") and [redacted] (the Appellant's "Guardian") that the Community First Choice ("CFC") budget for the Appellant's Personal Care Assistance ("PCA") was reduced from [redacted] hours per week to [redacted] hours per week.

On [redacted] 2024, the Appellant requested an administrative hearing to contest the Department's decision to reduce the weekly PCA hours.

On [redacted] 2024, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2024.

On [redacted] 2024, in accordance with sections 17b-60, 17b-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] Appellant
[redacted] Appellant's Guardian
[redacted] Appellant's Sister
[redacted] Community First Choice
Janette Steward, Nurse Consultant DSS

[redacted] Manager CT Community Care
Eric Bulewich, CFC Social Worker
Alisha Laird, Fair Hearing Officer

The Hearing record remained open to allow the Guardian to provide a statement after reviewing the hearing summary and exhibits. The Guardian did not provide any additional documentation or statements and the hearing record closed on [redacted] 2024.

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department's proposed CFC reduction of personal care assistance hours to [redacted] per week is correct.

FINDINGS OF FACT

1. The Appellant is [redacted] years old and has the following diagnosis [redacted] She receives services through the State of Connecticut Department of Development Services ("DDS") waiver program. (Exhibit 1: Hearing Summary and Exhibit 2: DDS Level of Need Assessment)

2. The Appellant lives with her mother, the Guardian, and receives Husky Medicaid from the Department. (Appellant's Sister Testimony)

3. The Appellant's Guardian is her personal care assistant ("PCA") through the CFC program. (Appellant's Sister Testimony)

4. The State of Connecticut Department of Development Services ("DDS") acts as a Medicaid operating partner under a Memorandum of Understanding with the Department of Social Services ("DSS"). (Exhibit 1)

5. The CFC program eligibility and budget are determined by the Recipients' level of need ("LON") scored by a universal assessment, to assess their functional status of Activities of Daily Living ("ADLs") and Instrumental Activities of Daily Living ("IADLs"). (Department's Testimony)

6. Activities of Daily Living include bathing, dressing, toileting, transferring, and eating. Instrumental Activities of Daily Living include meal planning and preparation, managing finances, shopping for essential items, performing household chores, communicating by phone, and traveling within the community. (Ex 1)

7. When a CFC recipient is active on another State waiver program the IADL portion of their LON is no longer considered. CFC will only look at the recipient's hands-on ADL needs. (Department's Testimony)

8. In 2019, CFC allocated a budget for the Appellant of [redacted] and [redacted] hours of PCA care per week, based on a LON assessment score of [redacted] ADL needs and [redacted] IADL needs. (Department's Testimony)

9. In 2021, Connecticut Community Care ("CCC"), the Department's access agency, completed an annual reassessment of the Appellant's LON. The Department reviewed the reassessment and determined the Appellant to have a LON of [redacted] The Department allocated a budget of [redacted] and [redacted] hours of PCA care per week. (Department's Testimony and Exhibit 4: Notice of Action)

10. In 2022, the Department discovered the Appellant was active on a waiver program with DDS. (Department's Testimony)

11. In 2023, CCC completed an annual reassessment of the Appellant's LON through telephone. The Department reviewed the reassessment and determined the Appellant to have a LON of [redacted] Due to the Public Health Emergency, there was no change to the Appellant's budget or reduction to their PCA hours. (Department's Testimony)

12. On [redacted] 2024, CCC completed an in-person reassessment of the Appellant's LON. The Department reviewed the reassessment and determined the Appellant to have [redacted] ADL needs and her IADL needs would continue to be supported and provided by the DDS waiver program. (Ex 1)

13. The Appellant receives [redacted] hours of services from the [redacted] Day program through her DDS waiver. (Appellant's Sister Testimony)

14. The Appellant PCA provides the following IADLs for the Appellant: [redacted]. (Appellant's Sister Testimony)

15. The Appellant needs prompting to perform household chores and grooming. (Appellant's Sister Testimony)

16. On [redacted] 2024, the Department issued a Notice of Action ("NOA") Community First Choice Program Service Budget Reduction notice to the Appellant and her Guardian. The notice listed the CFC budget as [redacted] with [redacted] hours of PCA services effective [redacted] 2024. (Ex 4)

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 Guardian requested an administrative hearing on [redacted] 2024; due to extending the closing of the record, this decision is due no later than [redacted] 2024.

CONCLUSIONS OF LAW

1. Connecticut General Statute ("Conn. Gen. Stats") section 17b-2(6) provides that the Department of Social Services is designated as the state agency for the administration of 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 for 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.

3. 42 C.F.R. § 441.500(b) provides for 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.

4. 42 C.F.R. § 441.505 defines Activities of daily living ("ADLs") as basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

5. 42 C.F.R. § 441.505 defines Instrumental activities of daily living (IADLs") as 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 in determining that the Appellant is [redacted] with all her ADLs and [redacted] assistance with her IADLs.

6. 42 C.F.R. § 441.515(b) provides states must provide Community First Choice to individuals: 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.

7. 42 C.F.R. § 441.510 provides for 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.

8. 42 C.F.R. § 441.520(a) provides 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.

9. 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.

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

10. 42 C.F.R. § 441.535 provides 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.

11. 42 C.F.R. § 441.540(b)(5) 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.

12. Connecticut State Plan Amendment ("SPA") no. 15-012, pursuant to section 1915(k) of the Social Security Act, § 5 (A) provides 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.

    On [redacted] 2024, the Department correctly completed a face-to-face reassessment of the Appellant's needs, strengths, preferences, and goals for the services and supports provided under the CFC.

    The Department correctly determined the Guardian is a source of natural support for the Appellant's ADLs and IADLs.

    The Department correctly determined the Appellant accesses her CFC services through the [redacted] Day program provided by her DDS waiver.

13. Conn. Gen. Stat. § 17b-259b(a) provides for Medically Necessary and Medical necessity. 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.

14. SPA 15-012 § 1(A) provides individuals who are receiving 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 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.

    The Department's reduction of the Appellant's PCA hours to [redacted] hours per week is adequate to meet her functional needs concerning her medical condition and overall health based on the [redacted] 2024, reassessment.

    The Department was correct when it determined that additional hours of PCA through CFC services are not medically necessary for the Appellant because the number of such services is not clinically appropriate, at this time, given the Appellant has [redacted] ADL needs and [redacted] at nursing home level of care. Additionally, the Appellant receives [redacted] hours of weekly Day program services provided by DDS for her IADLS needs and has natural family support provided by her Guardian.

15. 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.

16. 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] 2024, the Department correctly issued a Notice of Action Service Budget Reduction letter to the Appellant informing her that her CFC budget and service hours have been reduced allowing 30 days between the NOA and the effective date.

DECISION

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

Alisha Laird
Alisha Laird
Fair Hearing Officer

CC: [redacted]
Eric Bulewich, Department's Social Worker CFC

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.