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") 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 weekly PCA hours.

On [redacted] [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's Guardian
[redacted] Care Assessor, Connecticut Community Care
[redacted] Case Manager, Connecticut Community Care
Janette Stewart, Nurse Consultant, DSS
Cynthia Cartier, Department's Attorney
Alisha Laird, Fair Hearing Officer

STATEMENT OF THE ISSUE

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

FINDINGS OF FACT

1. The Appellant is [redacted] years old and resides with his father (the "Guardian") and mother. His diagnoses include but are not limited to [redacted]. (hearing Record and Guardian's Testimony)

2. The Appellant is a recipient of Husky C Medicaid. (Guardian Testimony)

3. The State of Connecticut Department of Developmental Services ("DDS") acts as a Medicaid operating partner under a Memorandum of Understanding with the Department of Social Services ("DSS"). (Hearing Record)

4. The CFC program eligibility and budget are determined by the Recipients' Level of Need ("LON") scored by a Universal Assessment ("UA"), to assess their functional status of Activities of Daily Living ("ADLs") and Instrumental Activities of Daily Living ("IADLs"). (Exhibit 9: State Plan Amendment)

5. The CFC program utilizes a standardized allocation chart to determine funding for ADLs and IADLs. The budget categories include the following: CFC only, no active Medicaid wavier-Budget A; CFC combined with Department of Developmental Services ("DDS") and Department of Mental Health and Addiction Services ("DMHAS") Waivers-Budget C; Children (17 years old and younger)-Budget D. (Exhibit 6: Budget Categories)

6. The Appellant receives services from a DDS waiver care program. The Department utilized Budget C, chart C1 for ADL only needs, to determine the Appellant's CFC program budget. DDS waiver care plans do not include funding for the ADL component of the Appellant's budget. (Hearing Record and Ex 6)

7. 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. (Exhibit 1: 2023 UA Outcome Form and Hearing Record)

8. Connecticut Community Care ("CCC") is an organization contracted by the Department to conduct the UA for the CFC program. (Hearing Record and Ex 9)

9. On [redacted] 2021, the Appellant applied for the CFC program. CCC conducted a UA on [redacted] 2021, and he was assessed to have a LON of [redacted] with [redacted] ADL for [redacted] On [redacted] 2021, the Department approved a budget amount of [redacted] for [redacted] weekly PCA hours. (Department's Testimony)

10. On [redacted] 2022, CCC conducted a face-to-face reassessment resulting in a LON of [redacted] with [redacted] ADLs for [redacted]. The Department granted a budget of [redacted] for [redacted] weekly PCA hours. (Department's Testimony)

11. On [redacted] 2023, CCC reassessed the Appellant's needs. He was found to have [redacted] ADLs for [redacted]. The Department granted a budget of [redacted] for [redacted] weekly PCA hours. (Department's Testimony, Ex. 1 and Exhibit 2: 2023 Revised CFC Budget)

12. On [redacted] 2024, CCC conducted a face-to-face reassessment resulting in [redacted] ADLs for [redacted]. The Department granted a budget of [redacted] for [redacted] weekly PCA hours. (Hearing Record and Exhibit 4: 2024 UA Outcome Form and Exhibit 5: 2024 Revised CFC Budget)

13. As of [redacted]2024, the Appellant's DDS waiver financial budget totals [redacted]. The DDS waiver covers the Appellant's IADL needs. The Appellant is pending a PRAT review to increase the DDS waiver budget. (Exhibit 7: DDS Assessment and Department's Testimony)

14. The Appellant has been active on a DDS waiver from 2021 through 2024. (Department's Testimony)

15. The Appellant needs hands-on assistance with [redacted] on occasion. (Guardian's Testimony)

16. The Appellant requires a [redacted] to assist with his [redacted]. (Guardian's Testimony)

17. The Appellant requires 24-hour supervision, and his care team consists of PCAs provided by CFC, an in-home support person provided by DDS, the school staff, and both parents. (Guardian's Testimony)

18. On [redacted] 2024, the Department issued the Appellant a Notice of Action ("NOA") Community First Choice program Services Budget Reduction notice. The notice indicated that the Department has proposed

to reduce his PCA hours to [redacted] hours per week and reduce his annual budget from [redacted] to [redacted] effective [redacted] 2024. (Exhibit 3: Notice)

19. 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; therefore, 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.

The Department has the authority to administer the CFC program.

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.

6. 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.

7. Connecticut State Plan Amendment (“SPA”) no. 15-012, pursuant to section 1915(k) of the Social Security Act, § 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 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 complete the universal assessment for each individual. The universal assessment confirms institutional level of care and individual level of need.

8. SPA No 15-012 § 1(C) provides, in part, as follows 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 services 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.

9. SPA No 15-012 § 7 provides, in part, for assessment of need. Confirmation of a participant's level of care is determined by information gathered by assessors at contracted entities during initial assessment and annual re-assessment via face-to-face interviews utilizing the Universal Assessment (UA). Both assessment and re-assessment include a thorough evaluation of the client's individual circumstances.

   The UA is based on the InterRAI tool. The UA is a validation tool used to confirm level of care and calculate a level of need based on the identified needs of the participant. The UA assesses a participant's Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) needs as well as taking into account their health, rehabilitation needs, and their natural supports.

10. 42 C.F.R. § 441.540(c) provides for reviewing the person-centered service plan. 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.

    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 Appellant would otherwise 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.

11. 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.

12. Conn. Gen. Stat. § 17b-259b(b) provides clinical policies, medical policies, clinical criteria or any other generally accepted clinical practice guidelines used to assist in evaluating the medical necessity of a requested health service shall be used solely as guidelines and shall not be the basis for a final determination of medical necessity.

13. 42 C.F.R. § 441.520(a) provides that 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.

14. SPA No 15-012 § 1(A) provides for eligibility. 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 19159(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 care 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.

15. 42 C.F.R. § 441.510(e) provides 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.

The Department's reduction of the Appellant's PCA hours to [redacted] hours per week is adequate to meet his functional needs concerning

his medical condition and overall health based on the [redacted] 2024, reassessment.

Per Federal regulation CFC recipients may receive additional services and support through other Medicaid programs such as the DDS waiver program, however, CFC recipients are not allowed to receive duplicative services from other available sources of Medicaid coverage for home and community-based services.

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's in-home IADL support services provided by DDS.

There is no medical evidence that the reduction in the Appellant's weekly PCA hours places him at immediate risk of institutionalization.

16. 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.

17. 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 him that his 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: Cynthia Cartier, JD LLM, Department's Attorney
Randell Wilson, Manager, CFC
[redacted]

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.