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STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
OFFICE OF HEARINGS AND APPEALS

In the Matter of	)	
	)	
[redacted],	)	OHA Case No. 09-FH-106
	)	
Claimant.	)	DPA Case No. [redacted]
	)	

FAIR HEARING DECISION

STATEMENT OF THE CASE

[redacted] (Claimant) was receiving Medicaid benefits under the Breast and Cervical Cancer Treatment category (Ex. 1). On February 10, 2009 Qualis Health Services [1] notified the Division of Public Assistance (DPA or Division) that the Claimant's cancer treatment had ended and requested that her Medicaid case be closed for that reason ([redacted] hearing testimony). On February 10, 2009 DPA closed the Claimant's Medicaid case based on the notification from Qualis Health Services (Ex. 2.1). On February 11, 2009 DPA mailed written notice to the Claimant advising her that her Medicaid case had been closed because "the Division of Public Health has reported that you are no longer undergoing treatment for breast or cervical cancer" (Exs. 3-4). The DPA notice further stated that "Aged / Disabled / LTC Medicaid Manual Section 575 supports this action." *Id.*

The Claimant submitted a Fair Hearing Request on February 16, 2009 (Exs. 4.1-4.2). This office has jurisdiction to resolve this dispute pursuant to 7 AAC 49.010.

A hearing was held on April 1, 2009 before Hearing Officer Patricia Huna-Jines. [2] The Claimant attended the hearing telephonically, represented herself, and testified on her own behalf. [redacted], a DPA Public Assistance Analyst, attended the hearing in person to represent and testify on behalf of the Division.

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[1] Qualis Health Services is a non-governmental entity which performs certain program eligibility review and quality assurance functions under contract with the Division.

[2] Following the hearing this case was reassigned to Hearing Officer Jay Durych, who reviewed the entire record, including listening to the digital recording of the hearing, prior to issuing this decision.

ISSUE

Was the Division correct to terminate the Claimant's Medicaid benefits under the Breast and Cervical Cancer Treatment category on February 11, 2009 because the Claimant's cancer treatments had ended?

FINDINGS OF FACT

The following facts were established by a preponderance of the evidence:

1. The Claimant was a participant of the Medicaid Breast and Cervical Treatment Program (Ex. 1).

2. On February 10, 2009 Qualis Health Services [3] notified DPA that the Claimant's cancer treatment had ended and requested that her Medicaid case be closed for that reason ([redacted] hearing testimony).

3. On February 10, 2009 DPA closed the Claimant's Medicaid case based on the notification from Qualis Health Services (Ex. 2.1).

4. On February 11, 2009 DPA mailed written notice to the Claimant advising her that her "Breast/Cervical Cancer Medicaid" case was being closed because "the Division of Public Health has reported that you are no longer undergoing treatment for breast or cervical cancer" (Exs. 3-4). The DPA notice further stated that "Aged / Disabled / LTC Medicaid Manual Section 575 supports this action." *Id.*

5. On February 16, 2009 the Claimant submitted a Fair Hearing Request (Exs. 4.1-4.2).

6. At the hearing of April 1, 2009 the Claimant testified that:

   a. She is a breast cancer survivor.

   b. If she had not had a mammogram, her previous breast cancer would probably not have been detected until it was too late to save her life.

   c. Because of her prior incidence of cancer, she will always be at a high risk of recurrence, both in her previously affected breast, and in her other breast.

   d. She cannot afford private health insurance because all of the insurers charge an extremely high monthly premium when a person discloses, on his or her application for health insurance, that the person has had cancer. In the Claimant's case the insurance premium charged by the Claimant's husband's insurer was or would be $1,100.00 per month.

   e. She cannot afford a mammogram or a doctor's checkup now because doctors are currently charging approximately $300.00 for one mammogram and $600.00 for a routine physical. She

[3] Qualis Health Services is a non-governmental entity which performs certain program eligibility review and quality assurance functions under contract with the Division.

cannot afford to pay such a large sum out-of-pocket now that she cannot get affordable health insurance.

f. Because of the Claimant's lack of health insurance and her inability to pay the high cost of health care out-of-pocket, if her cancer comes back, the Claimant will not be aware of it until it is too late because she cannot afford the necessary periodic preventive testing.

g. She would just like some type of coverage which would pay for the cost of periodic mammograms.

7. There was no evidence presented that the Claimant's cancer treatment plan extended past the DPA's February 11, 2009 notice of case closure.

8. The testimony of the Claimant and of the Division's representative was credible.

9. Based on the parties' hearing testimony, there are no disputed factual issues in this case.

PRINCIPLES OF LAW

I. Applicable Burden of Proof and Standard of Proof.

The party seeking a change in the status quo normally has the burden of proof. [4] This case involves the termination of Medicaid benefits by the Division. Accordingly, the Division has the burden of proof here because it is attempting to change the existing status quo by terminating preexisting Medicaid benefits.

The "preponderance of the evidence" standard is the standard of proof applicable to this case. [5] This standard is met when the evidence, taken as a whole, shows that the fact sought to be proved is more probable than not or more likely than not. [6]

II. Medicaid Program Background.

Because Medicaid is a federal program [6a], many of its requirements are contained in the Code of Federal Regulations (CFRs). The Medicaid program's general eligibility requirements are set forth at 42 CFR Sections 435.2 – 435.1102.

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4 *State of Alaska Alcoholic Beverage Control Board v. Decker*, 700 P.2d 483, 485 (Alaska 1985).

5 A party in an administrative proceeding can assume that preponderance of the evidence is the applicable standard of proof unless otherwise stated. *Amerada Hess Pipeline Corp. v. Alaska Public Utilities Commission*, 711 P.2d 1170 (Alaska 1986). The Medicaid regulations applicable to this case do not specify any particular standard of proof. Therefore, The standard of proof applicable to this case is the "preponderance of the evidence" standard.

6 *Black's Law Dictionary* at page 1064 (West Publishing, 5th Edition, 1979).

6a The Medicaid Program was enacted in 1965, creating a cooperative federal/state program in which the federal government reimburses states for a portion of the cost of medical care for persons in need. See Title XIX of the Social Security Act of 1965, 42 U.S.C. § 1396, et seq.; see also *Schweiker v. Gray Panthers*, 453 U.S. 34, 36, 101 S.Ct. 2633, 69 L.Ed.2d 460 (1981). The purpose of the program is to provide medical assistance to those whose resources are insufficient to meet the costs

The State of Alaska's statutes implementing the federal Medicaid program are set forth at A.S. 47.07.010 – A.S.47.07.900. The State of Alaska's regulations implementing the Medicaid program are set forth at 7 AAC 100.001 – 7 AAC 100.990.

The Medicaid program has a large number of eligibility groups; it covers needy individuals in a variety of circumstances. The Medicaid program regulation specifically dealing with coverage for breast and cervical cancer treatments is 7 AAC 100.710 (set forth below in Section III).

III. Breast and Cervical Cancer Medicaid Statutes and Regulations.

In 2000 Congress adopted the Breast and Cervical Cancer Prevention and Treatment Act ("BCCPTA"). This act amended the federal Medicaid statute to provide that each state's Medicaid program may offer Medicaid coverage to women with breast or cervical cancer if they met certain criteria. See 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVIII); § 1396(a)(xiii); § 1396a(aa); and § 1396a(a)(10(G)(XIV).

On July 20, 2007 the State of Alaska adopted a regulation to implement the BCCPTA in Alaska. That regulation, 7 AAC 100.710, provides in relevant part as follows:

> (a) To be eligible [for Medicaid coverage for breast or cervical cancer] under 7 AAC 100.002(d) (7), a woman must . . . . (2) . . . have been *determined to need treatment for breast, cervical, or directly related cancer* . . . . (Emphasis added)
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> * * * * * * * * * * * *
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> (b) A woman who is eligible for Medicaid under this section remains eligible during the period that the woman *is receiving treatment for breast, cervical, or directly related cancer* and meets the requirements of (a) of this section. *A woman is presumed to be receiving treatment for the duration of the period in the treatment plan established by the treating health care professional…* (Emphasis added).
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> * * * * * * * * * * * *

Section 575D of the Division of Public Assistance's "Aged, Disabled and Long Term Care Medicaid Eligibility Manual" provides in relevant part as follows:

> A woman may remain eligible for this [Breast and Cervical Cancer] Medicaid category *as long as she is undergoing treatment for breast, cervical, or a directly related cancer.* The woman's treating health care provider and Qualis Health work together to determine when her course of treatment is considered to have ended. *When her treatment ends, her Medicaid eligibility under this category also ends.* (Emphasis added).

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of necessary medical care. *Atkins v. Rivera,* 477 U.S. 154, 106 S.Ct. 2456, 91 L.Ed.2d 131 (1986).

IV. Court Decisions Involving State Regulations Implementing the Breast and Cervical Cancer Prevention and Treatment Act of 2000.

Research indicates that the only reported court decision construing the Breast and Cervical Cancer Prevention and Treatment Act is *Hauser v. Idaho Department of Health and Welfare*, 2004 WL 1854250 (Idaho Dist. Ct. 2004). This case involved the interpretation of Idaho's BCCPTA regulation. The claimant's doctor submitted a status report to the state agency stating that *the claimant had completed her chemotherapy and was currently undergoing maintenance therapy to maintain her in a stable condition and prevent relapse. Id.* The state agency terminated the claimant's benefits because (it asserted) her cancer treatment had ended. *Id.*

On appeal, the state agency asserted (among other points) that a claimant no longer requires treatment when she has no detectable evidence of cancer. *Id.* The claimant, however, presented expert medical testimony establishing that a five year course of drug treatment, with periodic follow-up visits to a physician, was part of the appropriate post-surgical treatment for breast cancer. *Id.* The court concluded that this long-term drug therapy constituted "treatment" under federal Medicaid law even though it occurred after the point where the claimant had no detectable evidence of breast cancer. *Id.* The court remanded the case to the state agency and ordered that the claimant's BCCPTA coverage be reinstated. *Id.*

ANALYSIS

I. Introduction.

There are no disputed factual issues in this case. The sole question for determination is the purely legal issue of whether the Medicaid Breast and Cervical Treatment Program, as established in Alaska by 7 AAC 100.710, covers mammograms and/or physician visits *after* a claimant's cancer treatment has ended.

II. Analysis.

This case is controlled by State regulation 7 AAC 100.710(b) and Section 575D of the Division of Public Assistance's "Aged, Disabled and Long Term Care Medicaid Eligibility Manual" (Manual). 7 AAC 100.710(b) provides in relevant part:

> (b) A woman who is eligible for Medicaid under this section *remains eligible during the period that the woman is receiving treatment for breast, cervical, or directly related cancer* and meets the requirements of (a) of this section. *A woman is presumed to be receiving treatment for the duration of the period in the treatment plan established by the treating health care professional.* (Emphasis added).

Manual Section 575D provides in relevant part that "a woman may remain eligible for [Breast and Cervical Cancer Medicaid] *as long as she is undergoing treatment for breast, cervical, or a directly related cancer . . . . When her treatment ends, her Medicaid eligibility under this category also ends.* (Emphasis added).

7 AAC 100.710(b) provides more specific guidance as to when "receiving treatment" ends and states, "*a woman is presumed to be receiving treatment for the duration of the period in the treatment plan established by the treating health care professional."* [Emphasis added]. In other words, the regulation creates a presumption that a woman remains eligible for Medicaid coverage until the end of the course of

treatment prescribed by her physician. Thus, pursuant to 7 AAC 100.710(b), the treatment plan established by the physician actually determines the duration of the Medicaid coverage.[7]

This principle is well illustrated by the case of *Hauser v. Idaho Department of Health and Welfare*, 2004 WL 1854250 (Idaho Dist. Ct. 2004) (discussed in the Principles of Law, above). The only relevant difference between this case and the *Hauser* case is the fact that, in *Hauser*, the cancer treatment plan established by the claimant's physician provided for continuing drug treatment and follow-up visits for a period of five years. In this case, however, the record indicates that the cancer treatment plan established by the Claimant's physician *did not* provide for such continuing care. In addition, Claimant did not dispute the DPA's assertion in its benefit termination notice that her cancer treatment had ended.

III. Summary and Conclusion.

Pursuant to 7 AAC 100.710(b), a woman who is otherwise eligible for Alaska's Medicaid under the Breast and Cervical Cancer Treatment Programcategory remains eligible for the program "during the period that the woman is *receiving treatment* for breast, cervical, or directly related cancer" (emphasis added) However, once the physician-defined treatment program ends, Medicaid coverage under 7 AAC 100.710(b) also ends. [8]

In this case there was no dispute that the Claimant's physician-defined cancer treatment program had ended. Accordingly, pursuant to 7 AAC 100.710(b), the Claimant's Medicaid Breast and Cervical Cancer Treatment Programcategory benefits also ended. The Division was therefore correct to terminate the Claimant's participation in the Medicaid Breast and Cervical Cancer Treatment Program on or about February 11, 2009.

CONCLUSIONS OF LAW

The Division carried its burden and proved, by a preponderance of the evidence, that:

1. The Claimant's breast cancer treatment ended prior to February 11, 2009.

2. The Claimant's Medicaid eligibility under the Breast and Cervical Cancer Treatment category ended, pursuant to 7 AAC 100.710(b) and Section 575D of the Aged, Disabled and Long Term Care Medicaid Eligibility Manual, when the Claimant's breast cancer treatment ended at some time prior to February 11, 2009.

3. The Division was therefore correct to terminate the Claimant's participation in the

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[7] Section 575D of the Division of Public Assistance's "Aged, Disabled and Long Term Care Medicaid Eligibility Manual" states that "the woman's treating health care provider and QUALIS Health work together to determine when her course of treatment is considered to have ended" [emphasis added]. However, the underlined portion of Section 575 of the Manual is not consistent with the analogous portion of the regulation (7 AAC 100.710). In the event of an inconsistency between the regulation and the Medicaid Eligibility Manual, the regulation controls. Accordingly, pursuant to 7 AAC 100.710(b), *it is the health care professional's judgment with regard to the claimant's treatment plan that is determinative*.

[8] Pursuant to 7 AAC 100.710(b), a woman's physician is free to select any cancer treatment plan that is medically appropriate, including a cancer treatment plant with long-term follow-up care.

Medicaid Breast and Cervical Cancer Treatment category on February 11, 2009.

DECISION

The Division was correct to terminate the Claimant's participation in the Medicaid Breast and Cervical Cancer Treatment category on February 11, 2009.

APPEAL RIGHTS

If for any reason the Claimant is not satisfied with this decision, the Claimant has the right to appeal by requesting a review by the Director. To do this, send a written request directly to:

Director of the Division of Public Assistance
Department of Health and Social Services
PO Box 110640
Juneau, AK 99811-0640

If the Claimant appeals, the request must be sent within 15 days from the date of receipt of this Decision. Filing an appeal with the Director could result in the reversal of this Decision.

DATED this _____ day of June, 2009.

_____
Jay Durych
Hearing Authority

CERTIFICATE OF SERVICE

I certify that on this _____ day of June, 2009, true and correct copies of the foregoing were sent to the Claimant via U.S.P.S. mail, and to the remainder of the service list by e-mail, as follows:

Claimant – Certified Mail, Return Receipt Requested
[redacted], Director
[redacted], Policy & Program Development
[redacted], Staff Development & Training
[redacted], Administrative Assistant II
[redacted], Eligibility Technician I
[redacted], Fair Hearing Representative

By_____
J. Albert Levitre, Jr.
Law Office Assistant I