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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-2100
	)	
Claimant.	)	DSDS Case No. [redacted]
	)	

FAIR HEARING DECISION

STATEMENT OF THE CASE

Prior to September 14, 2009 [redacted] (Claimant) was a resident of the [redacted] Medical Center Long-Term Care Facility and had previously received Medicaid authorization for long-term care at that facility (Ex. D-1). On September 14, 2009 the State of Alaska Division of Senior and Disabilities Services (DSDS or Division) mailed a notice to the Claimant stating that it would terminate the Claimant's authorization for long-term care (cease payment for the Claimant's stay at the [redacted] Medical Center Long-Term Care Facility), "effective October 14, 2009," based on the assertion that, as of that date, the Claimant did not require either skilled or intermediate-level nursing care (Exs. D-1 to D-3). On September 23, 2009 the Claimant requested a hearing with regard to DSDS' termination of Medicaid payment for his nursing home care (Ex. C-1). [1]

On September 15, 2009 the Claimant and his caregivers prepared and signed an application for the General Relief (GR) Assisted Living Home Care Program in an effort to obtain payment for continued residence at the [redacted] Medical Center Long-Term Care Facility through the GR Program (Exs. F-2 through F-9). The Claimant's General Relief Assisted Living Home Care Program application was submitted to the Division on September 16, 2009 (Ex. F-1). The Division denied the Claimant's GR application later that day (Exs. F-10, F-11, F-51). On October 9, 2009 the Claimant requested a hearing with regard to DSDS' denial of the Claimant's application for General Relief (Ex. C-2).

[1] This matter is sometimes subsequently referred to in this decision as "the non-waiver level-of-care determination."

On an unknown date prior to November 5, 2009 the Claimant applied for Medicaid benefits under the Home and Community-Based Waiver Services Program (hereafter "HCBW" or "Waiver program"). [2] On November 5, 2009 the Division mailed to the Claimant a notice stating that his application for benefits under the Medicaid Home and Community-Based Waiver Services Program had been denied on the basis that his assessment of September 29, 2009 indicated that he did not require either skilled-level or intermediate-level nursing care (Exs. D-4 to D-6). The Claimant requested a fair hearing contesting the denial of his application for HCBW benefits at some time subsequent to that date. [3]

This Office has jurisdiction to decide this case pursuant to 7 AAC 49.010.

On November 9, 2009 [redacted], Esq. (Disability Law Center of Alaska) entered her appearance as counsel for the Claimant. On November 12, 2009 [redacted], Esq. (Department of Law, Attorney General's Office) entered her appearance as counsel for DSDS.

On December 11, 2009 the Claimant requested that the matter involving DSDS' termination of the Claimant's Medicaid authorization for nursing home care, and the matter involving DSDS's denial of the Claimant's application for HCBW services, be consolidated and considered together in this case. The matter involving DSDS' denial of the Claimant's application for General Relief would be bifurcated and heard separately. DSDS did not oppose the Claimant's request. Accordingly, an order bifurcating the General Relief matter for separate disposition was entered on December 14, 2009.

Hearings were held in this case on December 21, 2009, December 29, 2009, January 22, 2010, March 5, 2010, and June 21, 2010 before Hearing Examiner Jay Durych.

The December 21, 2009 hearing was attended by Ms. [redacted], Ms. [redacted], [redacted], the State of Alaska's Long Term Care Ombudsman, [redacted], R.N. of DSDS, [redacted] of DSDS, [redacted] of the Disability Law Center of Alaska, and [redacted], the Claimant's brother. Participating by telephone were the Claimant, [redacted], Long Term Care Supervisor of the [redacted] Medical Facility, [redacted], MSW of the [redacted] Medical Facility, and Dr. [redacted]. [redacted], M.D. Those testifying were Ms. [redacted], Mr. [redacted], and Dr. [redacted].

The December 29, 2009 hearing was attended by Ms. [redacted], Ms. [redacted], [redacted], the State of Alaska's Long-Term Care Ombudsman, and [redacted], R.N. of DSDS. The Claimant, [redacted], and [redacted] participated by telephone. Mr. [redacted], Ms. [redacted], Ms. [redacted], the Claimant, and Ms. [redacted] testified.

The January 22, 2010 hearing was attended by Ms. [redacted], Ms. [redacted], [redacted], the State of Alaska's Long-Term Care Ombudsman, [redacted] of the Disability Law Center of Alaska, the Claimant's brother [redacted], and the Claimant himself. Dr. [redacted], M.D. participated by telephone. Dr. [redacted] and [redacted] testified.

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[2] Although the record does not appear to reflect the exact date of the Claimant's HCBW application, the specific application date is not required for the resolution of this matter.

[3] Although the record does not appear to reflect the exact date of the Claimant's request for a hearing with regard to the denial of his HCBW application, the Division did not contest the timeliness of the Claimant's hearing request. Accordingly, the specific date of the Claimant's HCBW hearing request is not required for the resolution of this matter.

The March 5, 2010 hearing was attended by Ms. [redacted], Ms. [redacted], [redacted], R.N. of DSDS, [redacted], the State of Alaska's Long-Term Care Ombudsman, and [redacted]. The Claimant participated by telephone. Ms. [redacted] testified.

The June 21, 2010 hearing was attended by Ms. [redacted]. Ms. [redacted], Dr. [redacted], and the Claimant participated by telephone. Dr. [redacted] testified.

The witnesses' testimonies were received and all exhibits submitted were admitted into evidence. At the end of the hearings the record was closed except for submission of post-hearing briefs. [4] The parties' opening post-hearing briefs were filed on July 16, 2010. The parties' post-hearing reply briefs were filed on August 6, 2010. Following completion of this post-hearing briefing, the record was closed and the case became ripe for decision.

ISSUES

1. Was the Division correct when, on September 14, 2009, it notified the Claimant that it would terminate Medicaid coverage for the Claimant's stay at the [redacted] Medical Center Long-Term Care Facility, effective October 14, 2009, based on the assertion that the Claimant did not require either skilled or intermediate level [5] nursing care?

2. Was the Division correct when, on November 5, 2009, it denied the Claimant's September 2009 application for Medicaid Home and Community-Based Waiver Services, based on the assertion that the Claimant did not require either skilled or intermediate level [6] nursing care?

SUMMARY OF DECISION

As of September 14, 2009 the Claimant did not require either a skilled nursing facility level of care or an intermediate nursing facility level of care. Accordingly, the Division was correct when, on September 14, 2009, it notified the Claimant that it would terminate Medicaid nursing home certification / coverage for the Claimant's stay at the [redacted] Medical Center Long-Term Care Facility effective October 14, 2009.

During the year ending September 29, 2009 the Claimant did not require either a skilled nursing facility level-of -care or an intermediate nursing facility level-of-care. Accordingly, the Division was correct when, on November 5, 2009, it denied the Claimant's application for participation in the Medicaid Home and Community-Based Waiver Services Program.

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[4] The Claimant's post-hearing briefing was submitted by [redacted], Esq. of the Disability Law Center of Alaska. This Office appreciates the time and effort invested by both sides in the hearing and briefing of this matter.

[5] The Claimant did not assert that he required an Assisted Living level of care as defined in 7 AAC 47.300 – 47.310. Accordingly, this case *does not involve* the issue of whether the Claimant requires an Assisted Living level of care at an Assisted Living Facility (ALF) or assisted living home. Assisted living homes provide nonmedical residential care. 7 AAC 47.300. This "includes more than housing and food service, but does not include continuous nursing or medical care." 7 AAC 47.310. "Assisted living care encompasses 24-hour supportive and protective services of daily living and in the instrumental activities of daily living . . ." . 7 AAC 47.310.

[6] *See* footnote 5, above.

FINDINGS OF FACT

The following facts [7] were established by a preponderance of the evidence:

1. The Claimant was born [redacted], 1947 and was 62 years old at the time he requested hearings on the actions at issue in this case (Ex. F-12).

2. The Claimant was admitted to [redacted] Medical Center's Long-Term Care Facility on or about January 19, 2009 (Ex 1 pp 19 to 23; Ex. 2.1; [redacted] testimony). He was in long-term care due to a combination of a previous stroke, morbid obesity, and difficulty getting around (Ex. 1 p.10). He also had long-standing diabetes, which had been managed with relatively high doses of insulin (Ex. 1 p.15).

3. Radiology reports dated March 31, 2009 indicate that the Claimant has moderate degenerative changes in his lumbar and cervical spine (Ex. 1 pp 2-7).

4. On May 7, 2009 [redacted] of [redacted] Medical Center contacted the Office of the Long-Term Care Ombudsman to explore possible living arrangements for the Claimant (Ex. 2.1). The ombudsman's report indicates that Ms. [redacted] listed the Claimant's behavioral challenges as follows:

> Verbal attacks towards staff and other residents, attempts to play staff off against each other, refusal to perform self-care activities that he is perfectly capable of doing without assistance (washing hair and beard, assisting with TED hose, etc.), continuous snacking and expressing anger if healthy alternatives are offered, call[ing] for kitchen snacks to be brought to him instead of going to the day room to request, yelling profanities, not responding to staff intervention, [taking] food from other resident's trays after they leave the dining area, refus[ing] to self-inject insulin, stating "it's your job," verbally aggressive towards others in the community when out of the facility, unstable moods with frequent outbursts, improper use of medication (Nasonex) in spite of staff instructions, and sexual innuendos toward some staff.

The report also stated that Ms. [redacted] was "looking at facilities that would be appropriate for transfer, ICF or Assisted Living" (Ex. 2.1).

5. A report by the Claimant's physical therapist dated May 13, 2009 states in relevant part that the Claimant's "range of motion is within function limits, strength is within normal limits, bed mobility and transfers [are] independent, [and] gait independent with walker" (Ex. 1 p 8).

6. A report by the Claimant's physical therapist dated August 12, 2009 states in relevant part that the Claimant's "gross range of motion is within function limits, strength is within function limits, bed mobility and transfers are independent with walker [and] [p]atient's balance is good and [he] could ambulate with a cane" (Ex. 1 p 9).

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[7] Because the level-of-care determination is central to both the non-waiver termination of Medicaid nursing home authorization, and the denial of HCBW services, these Findings of Fact are equally applicable to both cases.

7. A report by [redacted], M.D., M.P.H. dated September 9, 2009 (Ex. 1 pp 24-26) states in relevant part as follows:

> This patient has profound insulin resistance reflected in his extremely high insulin dosing. The patient is on well over 200 units a day of insulin . . . . Until he brings his dietary habits under better control, I suspect that he would need to continue on these large doses of insulin . . . . There is no question that this patient's huge insulin requirement is probably driving his hunger and making him eat more causing a very vicious cycle.
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> * * * * * * * * * * * * *
>
> . . . . He is fully ambulatory at the present time. He should be encouraged to give all his own insulin shots and do insulin checks. He should be encouraged by the nursing staff at all times to attend to his self-care. It was unclear to me whether this gentleman is a candidate for long-term care in a nursing home. At the present time I cannot see any absolute contraindication to him living independently . . . .

8. On September 10, 2009 [redacted] physician [redacted], M.D. contacted Ms. [redacted] of DSDS and advised that he needed to discharge the Claimant from the [redacted] LTC facility because (in his opinion) the Claimant was no longer eligible for long-term care ([redacted] testimony). On September 10, 2009 Dr. [redacted] wrote a letter to DSDS. In that letter Dr. [redacted] stated that, in his opinion, there was "no medical or psychiatric reason for [the Claimant's] continued care in a Long-Term Care (LTC) facility" (Ex. H-1). Dr. [redacted] further stated in the letter that, in his opinion, the Claimant did not qualify for "a Medicaid waiver for an assisted living facility." *Id.*

9. On September 15, 2009 the Claimant and his caregivers prepared and signed an application for the General Relief (GR) Assisted Living Home Care Program (Exs. F-2 through F-9). [8] In conjunction with this application, [redacted] physician [redacted], M.D. diagnosed the Claimant as suffering from morbid obesity, diabetes mellitus type 1, hypertension, anxiety, depression, edema, constipation, GERD, anti-social behavior, and passive-aggressive behavior (Exs. F-5, F-13).

10. The Physician's Report dated September 15, 2009, submitted with the Claimant's Application for General Relief (see footnote 5, below), indicates that, as of that date, the Claimant was taking 21 different medications and that he was able to self-administer his Lantus and Nolovin insulin injections "with supervision" (Exs. F-4, F-12).

11. The Claimant was assessed for HCBW eligibility on September 29, 2009 (Ex. E-1). The person conducting the assessment was [redacted], a registered nurse employed by DSDS. *Id.* Present for the assessment were the Claimant, his care coordinator, and Ms. [redacted] (Ex. E-1).

12. Ms. [redacted] completed a Consumer Assessment Tool or "CAT" based on the HCBW assessment she performed on September 29, 2009 (Exs. E-1 – E-17; [redacted] testimony). She scored the Claimant with a "0" and found that he did not qualify for a nursing facility level-of-care or HCBW Program services (Ex. E-14). Specifically, Ms. [redacted]'s assessment found that, as of September 29, 2009:

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[8] As indicated in the Statement of the Case, above, the General Relief matter was bifurcated from the other two matters prior to hearing. Accordingly, this decision does not address the General Relief matter except to the extent that evidence submitted in support of the General Relief application is relevant to the two matters at issue here.

a. The Claimant did not require any professional nursing services and scored zero in each sub-category of this section (Exs. E-2, E-4).

b. The Claimant required no special treatments or therapies and scored zero in each sub-category of this section (Ex. E-4).

c. The Claimant had some difficulty in making decisions involving new situations (i.e. he was not completely independent in this regard) (Ex. E-5). Otherwise, however, the Claimant had no other cognitive problems and scored zero in each cognitive sub-category (Exs. E-5, E-7). Specifically, the Claimant could (i) recall details and sequences of events and remember the names of meaningful acquaintances; (ii) did not have difficulty remembering and using information, and did not require directions or reminding from others; (iii) respond appropriately to his environment without confusion; (iv) orient himself and keep his bearings; and (v) speak normally (Exs. E-5, E-7).

d. The Claimant did not require professional nursing assessment, observation and management of any problem behaviors at least three (3) days per week, or even once per month (Ex. E-5), and scored zero in each sub-category of this section (Ex. E-7).

e. The Claimant was able to turn and reposition himself in bed (i.e. he had good bed mobility) (Exs. E-2, E-6). He received a self-performance code of 0 (independent) and a support code of 0 (none required) in this category (Exs. E-2, E-6).

f. The Claimant had no significant difficulty moving (transferring) himself to and from a bed, couch, chair, etc; he did not need physical assistance to transfer (Exs. E-2, E-6). He received a self-performance code of 0 (no assistance required) and a support code of 0 (no assistance required) in this category (Exs. E-2, E-6).

g. The Claimant sometimes used a cane or walker to get around, but was also able to walk without anyone's help and without any assistive devices (Ex. E-2). He received a self-performance code of 0 (no assistance required) and a support code of 0 (no assistance required) in this category (Exs. E-2, E-6).

h. The Claimant is able to dress himself with no assistance (Exs. E-2, E-6). He received a self-performance code of 0 (no assistance required) and a support code of 0 (no assistance required) in this category (Exs. E-2, E-6).

i. The Claimant did not require any hands on assistance with eating (Exs. E-2, E-6). He received a self-performance code of 0 (independent – no assistance required) and a support code of 0 (no assistance required) in this category (Ex-9).

j. The Claimant required no physical assistance with transferring or personal hygiene when using the toilet (Exs. E-2, E-6). He received a self-performance code of 0 (no assistance required) and a support code of 0 (no assistance required) in this category (Exs. E-2, E-6).

k. The Claimant is able to perform his own personal care / hygiene (Exs. E-2, E-6). He received a self-performance code of 0 (no assistance required) and a support code of 0 (no assistance required) in this category (Exs. E-2, E-6).

l. The Claimant showers twice a week (Ex. E-2). He needs no help to transfer or wash, although he received assistance with washing his back, and insists that staff use a Hoyer lift because "he likes it." *Id.* He received a self-performance code of 0 (no assistance required) and a support code of 0 (no assistance required) in this category (Exs. E-2, E-6).

m. The Claimant prepared and administered some of his own medications, including his insulin and glucoscan within the seven days prior to the assessment (Ex. E-8). The Claimant was found to be "always compliant" in taking his medications (Ex. E-8).

n. The Claimant had no problems with hearing, speaking, or seeing, other than the need to wear glasses or contact lenses to correct his vision (Ex. E-9).

o. The Claimant had no incontinence problems within the 14 days prior to the assessment (Ex. E-11).

p. The Claimant had no problems with balance or falling (Ex. E-11).

q. The Claimant had dentures or a removable bridge but otherwise had no significant dental problems (Ex. E-11).

r. With regard to skin problems, the Claimant had some rashes, itchiness, and an open sore or lesion, but had no pressure ulcers (Ex. E-11).

s. The Claimant had no problems with his mood or sleep (Ex. E-11).

t. The Claimant needed help with many of his Instrumental Activities of Daily Living (IADLs) (Ex. E-12). Specifically, he needed help with meal preparation, managing his finances, routine housework, and laundry. *Id.*

13. The Claimant had an open wound on his toe at the time of his assessment ([redacted] testimony). The Claimant had this wound at least since September 1, 2009 and had received care for it from a doctor (Ex. 1 p. 24).

14. On November 4, 2009 [redacted], M.D. prepared and signed a Physician's Report in conjunction with the Claimant's Application for General Relief (Exs. I-1 through I-4). In that report, Dr. [redacted] diagnosed the Claimant as suffering from CVA, morbid obesity, diabetes mellitus II, chronic venous stasis, intermittent ulcers, hypertension, chronic back and lower extremity pain, and "personality disorder / mood disorder / depression / disruptive behavior – verbal at times" (Ex. I-3). Dr. [redacted] also testified that the Claimant suffers from chronic kidney disease. As of November 4, 2009, Dr. [redacted]'s recommendation was that the Claimant be placed in "assisted living with meals provided," and that he receive "assistance with medications / overseeing his diabetes," monitoring [of] skin integrity," and "opportunity for social contact" (Ex. I-4).

15. On November 3, 2009 [redacted], a registered nurse employed by the Division, reviewed the September 29, 2009 assessment and compared it to the factors listed in the State of Alaska *Manual for Prior Authorization of Long Term Care Services* in order to determine whether the Claimant required a skilled or intermediate level of nursing care and/or qualified for HCBW Program services (Exs. D-7, D-8; [redacted] testimony). Ms. [redacted] did not find any factors indicating that the Claimant required a skilled level of nursing care. *Id.* She likewise did not find any factors indicating that the Claimant required an intermediate level of nursing care (Ex. D-8).

16. [redacted], Assistant Director of Nursing at the [redacted] LTC facility, credibly testified in relevant part that:

a. The [redacted] LTC facility provides skilled and intermediate level nursing care.

b. The Claimant was not administering all his own insulin shots as of September 2009, and did not begin doing so until mid-November 2009 at the earliest.

c. She did not believe that the Claimant could be discharged home safely from the [redacted] LTC facility.

17. [redacted], a social worker at the [redacted] LTC facility, credibly testified in relevant part that:

a. The [redacted] LTC facility provides skilled and intermediate level nursing care.

b. The Claimant's problem behaviors are not unique; other nursing home residents have similar problems. The behavioral plan which the [redacted] LTC facility implemented helped improve the Claimant's problem behaviors.

c. She did not *believe* that the Claimant could be safely discharged from the [redacted] LTC facility.

18. Dr. [redacted], M.D., a physician in [redacted], Alaska who had been the Claimant's treating physician for the majority of 2009, credibly testified in relevant part that:

a. It is likely that the Claimant's problem behaviors are caused partially by his medical conditions, over which he has no control, and partially by his personality disorder, over which he might have limited control.

b. During September 2009 the Claimant was sometimes able to administer his own insulin, but he was not able to self-administer his own insulin all the time during that period.

c. For a few days in September 2009 the Claimant was taking insulin on a sliding scale, which is difficult for a patient to self-administer. The need for administration of insulin on a sliding-scale basis usually indicates the need for nursing services.

d. She did not believe that the Claimant could be discharged home alone safely from the [redacted] LTC facility; he would need support.

e. Were the Claimant discharged home, she was not sure whether care by non-nursing personnel would be sufficient because of the Claimant's need for insulin and the possibility of a hypoglycemic reaction.

f. She and other [redacted] LTC facility staff had been looking for an assisted living facility to which the Claimant could be transferred for some time.

19. Dr. [redacted], M.D., a doctor in [redacted], Alaska who was the Claimant's treating physician from May – September 2009, credibly testified in relevant part that the Claimant was sometimes non-compliant in the taking of his medications.

20. [redacted], R.N. of DSDS credibly testified in relevant part that patients who resist care require supervision, but that this required supervision does not equate to a need for professional nursing services. The only problem behaviors which are significant to a level-of-care assessment are problem behaviors which require nursing level care.

21. [redacted], R.N. of DSDS credibly testified in relevant part that:

a. She is a registered nurse employed by DSDS. She conducts level-of-care (LOC) reviews for DSDS. Her job functions and responsibilities are the same or very similar to those of [redacted], the DSDS nurse who reviewed the Claimant's assessment (*see* Paragraph 15, above).

b. She is familiar with the Division's *Manual for Long Term Care* (*Manual*) and uses it on a regular basis in making LOC determinations.

c. Prior to testifying in this case she reviewed the *Manual* LOC factors and all of the information / documentation which DSDS had available concerning the Claimant. Based on that review she concluded that the Claimant did not require skilled level or intermediate level nursing care.

d. As long as the Claimant is on a standard dose of insulin (and not on a sliding scale), his insulin could be managed at an Assisted Living Facility (ALF), although he would need supervision due to his resistance to taking medication. His blood sugar testing could also be supervised at an ALF.

e. Patients who resist care require supervision, but this required supervision does not equate to a need for professional nursing services.

f. Even if the Claimant received a score in the behavioral section of the CAT, he would still not meet LOC because his problem behaviors do not require hands-on professional nursing care.

g. The ALF level-of care is a step down from the intermediate level of care. A person who needs an ALF level-of-care for safety and supervision does not require a nurse and does not meet a nursing level-of-care.

h. People who do not require a nursing level-of-care are sometimes placed in nursing facilities either because a doctor writes a justification for placement in the nursing facility, or because there is no other place to put them.

PRINCIPLES OF LAW

I. Burden of Proof and Standard of Proof.

This case involves two separate matters which were consolidated for hearing and decision. The first matter involves the Division's decision to cease (terminate) payment for the Claimant's stay at the [redacted] Medical Center Long-Term Care Facility. The second matter involves the Division's denial of the Claimant's subsequent application for Choice Waiver services.

The party seeking a change in the status quo or existing state of affairs normally bears the burden of proof. [9] In the first matter (involving the Division's decision to cease (terminate) payment for the Claimant's stay at the [redacted] Medical Center Long-Term Care Facility), the Division is the party seeking to change the status quo, and the Division therefore bears the burden of proof in that matter.

In the second matter (involving the Division's denial of the Claimant's subsequent application for Choice Waiver services), the Claimant is the party seeking to change the status quo by obtaining benefits, and the Claimant therefore bears the burden of proof in that matter.

The regulations applicable to this case do not specify any particular standard of proof. Therefore, the "preponderance of the evidence" standard is the standard of proof applicable to this case. [10] This standard is met when the evidence, taken as a whole, shows that the facts sought to be proved are more probable than not or more likely than not. [11]

II. The Medicaid Program – In General.

Medicaid was established by Title XIX of the Social Security Act in 1965 to provide medical assistance to certain low-income needy individuals and families. 42 USC § 1396 et. seq. Medicaid is a cooperative federal-state program that is jointly financed with federal and state funds. *Wilder v. Virginia Hospital Association,* 496 U.S. 498, 501, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990).

Because Medicaid is a federal program, many of its requirements are contained in the Code of Federal Regulations (CFRs) at Title 42, Part 435 and Title 45, Part 233. The Medicaid program's general eligibility requirements are set forth at 42 CFR Sections 435.2 – 435.1102.

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

10 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).

11 *Black's Law Dictionary* at 1064 (West Publishing, 5th Edition, 1979); *see also Robinson v. Municipality of Anchorage*, 69 P.3d 489, 495-496 (Alaska 2003) ("Where one has the burden of proving asserted facts by a preponderance of the evidence, he must induce a belief in the minds of the triers of fact that the asserted facts are probably true").

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 in the Alaska Administrative Code at Title 7, Chapters 43 and Chapters 100 – 160.

III. "Non-Waiver" Medicaid Authorization for Long Term Care.

At the time of the Division's termination of the Claimant's Medicaid authorization for long term care in September 2009, the Division's standards for payment of skilled nursing facility (SNF) and intermediate care facility (ICF) services under the Medicaid program were governed by the regulations then set forth at 7 AAC 43.005 and 7 AAC 43.170 et. seq.

7 AAC 43.180,[12] titled "Skilled Level of Care," provides as follows:

> (a) Skilled care is characterized by the need for skilled nursing or structured rehabilitation ordered by and under the direction of a physician; these services must be provided either directly by or under supervision of qualified technical or professional personnel, who must be on the premises at the time service is rendered . . . .
>
> (b) Skilled nursing services are the observation, assessment, and treatment of a recipient's unstable condition requiring the care of licensed nursing personnel to identify and evaluate the recipient's need for possible modification of treatment, the initiation of ordered medical procedures, or both, until the condition improves to the point of stabilization.

7 AAC 43.185,[13] titled "Intermediate Level of Care," provides as follows:

> (a) Intermediate care is characterized by the need for licensed nursing services ordered by and under the direction of a physician, provided in a certified ICF and not requiring care in a hospital or SNF. [14]
>
> (b) Intermediate nursing services are the observation, assessment, and treatment of a recipient with long-term illness or disability whose condition is relatively stable and where the emphasis is on maintenance rather than rehabilitation, or care for a recipient nearing recovery and discharge whose condition is relatively stable but who continues to require professional medical or nursing supervision.
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> (c) Services provided in an ICF encompass a range from the skilled level to those above residential care as defined in 7 AAC 43.280.
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> (d) Intermediate care may include therapy provided by an aide or orderly under the supervision of licensed nursing personnel or a therapist.

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12 7 AAC 43.180 is applicable to *both* the non-waiver LOC determination *and* the HCBW LOC determination.

13 7 AAC 43.185 is applicable to *both* the non-waiver LOC determination *and* the HCBW LOC determination.

14 The acronyms "ICF" and "SNF" contained in 7 AAC 43.185 refer to "intermediate care facility" and "skilled nursing facility," respectively. *See* 7 AAC 43.1110(10), set forth above.

7 AAC 43.190,[15] titled "Determination of Level of Care," provides as follows:

> Whether a recipient's level-of-care needs are best met by skilled care or intermediate care is determined by considering the type of care required, the qualifications of the person necessary to provide direct care, and whether the recipient's overall condition is relatively stable or unstable. The division or the division's designee will make a level-of-care evaluation in accordance with the guidelines established in the Criteria for Placement section of the *Manual for Prior Authorization of Long Term Care Services . . . .* The division will make the final level-of-care decision based upon that evaluation. Oral information may not be accepted to support a level-of-care decision.

At the time of the Division's termination of the Claimant's Medicaid authorization for long term care in September 2009, 7 AAC 43.210, titled "Placement And Level-Of-Care Planning," provided in relevant part as follows:

* * * * * * * * * * * *

> (b) The following procedures apply only to those recipients who are already receiving care in an ICF or an SNF or who are in their home or other non-acute care setting who appear to require placement in a long-term care facility:
>
> > (1) . . . . [T]he long-term care facility shall complete a Request for Nursing Home Authorization form with all pertinent medical and social factors to justify the level-of-care request, including consideration of alternative placement for the recipient, the care prescribed by the attending physician, and physician notes, and submit the form to the utilization review committee; the utilization review committee at its next scheduled meeting will be responsible for reviewing the appropriateness of the level-of-care placement and the medical necessity for continued placement; the decision of the utilization review committee must be indicated on the Request for Nursing Home Authorization and submitted to the division [or its designee] by the long-term care facility;
> >
> > (2) the medical practice review section of the division will evaluate the Request for Nursing Home Authorization and the recommendation of the utilization review committee and either concur in the placement or request that additional information be reviewed by the utilization review committee to support the level-of-care decision; upon re-submittal of the Request for Nursing Home Authorization, if the medical practice review section does not find that sufficient justification exists to continue the recipient's present level-of-care placement, the division will so advise the facility;

[15] 7 AAC 43.190 is applicable to *both* the non-waiver LOC determination *and* the HCBW LOC determination.

> (3) the facility will have 30 days to arrange for discharge or alternative placement of a recipient who has been found by the medical practice review section to no longer be in need of care at his or her present level-of-care placement . . . .
>
> (c) The following procedures apply to all recipients who are new or continuing long-term care facility placements:
>
> (1) there must be a current, approved Request for Nursing Home Authorization in the division case file supporting each recipient's level-of-care placement; subsequent request forms must be submitted no less than semi-annually following admission to an ICF and no less than quarterly following admission to an SNF;
>
> (2) the Request for Nursing Home Authorization form must be precise as to the medical reason for continued stay and, where appropriate, should indicate what alternative types of medical care have been considered; the facility must provide information on the [form] supporting the level-of-care decision of the utilization review committee; the [form] must also explain the plan of care established for the treatment prescribed by the attending physician and documented in the facility's patient file by physician and nursing notes as well as the evaluation of social workers, therapists, and other health care professionals involved in the recipient's care; the [form] must include discussion of the following factors related to the recipient's care: diagnoses, symptoms, complaints, and complications indicating the need for admission or continued stay; a description of the functional level of the recipient; written objectives; orders (as appropriate) for medications, treatments, restorative and habilitative services, therapies, diet, activities, social services, and special procedures designed to meet these objectives; plans for continuing care (including provisions for review and necessary modifications of the plan); reasons why alternative placement is not feasible or appropriate; and plan for discharge;
>
> * * * * * * * * * * *

At the time of the Division's termination of the Claimant's Medicaid authorization for long term care in September 2009, 7 AAC 43.270(a), titled "Discharge of Recipients, provided as follows:

> (a) When the utilization review committee or the medical practice review section recommends that a recipient does not, or in the future will not, require continued long-term care placement, the recipient . . . shall be given 10 days' written notice before discharge. Recipients who receive notice of a proposed discharge have the hearing rights set out in 7 AAC 49.

IV. The Manual for Prior Authorization of Long Term Care Services.

Pursuant to 7 AAC 43.190, The Division is required to make its level-of-care evaluation in accordance with the guidelines established in the Criteria for Placement section of the *Manual for Prior*

Authorization of Long Term Care Services. [16] The "Criteria for Nursing Home Placement" section of the *Manual* contains two sets of factors: one for "skilled level of care" and another for "intermediate level of care." (*see* Ex. B at pp. 39-43).

The "Skilled Level of Care" factors are: (1) whether a patient requires 24 hour observation and assessment by a registered nurse or licensed practical nurse; (2) whether a patient requires intensive rehabilitative services, which is defined as 5 days or more per week of physician ordered physical, occupational, respiratory or speech therapy; (3) whether a patient requires 24 hour performance of direct services that must be furnished by a registered nurse, licensed practical nurse or someone acting under their supervision; (4) whether the patient requires medications that are administered either intravenously or by naso-gastric tube; (5) whether the patient has a colostomy-ileostomy; (6) whether the patient has a gastrostomy; (7) whether the patient is on oxygen; (8) whether the patient has a tracheostomy; (9) whether the patient is undergoing either radiation therapy or cancer chemotherapy; (10) whether the patient has sterile dressings that require prescription medication; (11) whether the patient has decubitus ulcers; (12) whether the patient has uncontrolled diabetes; and (13) whether the patient has unstabilized medical conditions requiring skilled nursing, such as a new stroke, new fractured hip, new amputation, being in a coma, terminal cancer, new heart attack, uncompensated congestive heart failure, or new paraplegia or quadriplegia. (Ex. B, pp. 39-40).

The "Intermediate Level of Care" factors are: (1) whether a patient requires 24 hour observation and assessment by a registered nurse or licensed practical nurse; (2) whether a patient requires restorative services, which include encouraging, assisting or supervising the patient in self-care, transfers, ambulation, positioning and alignment, range or motion, and/or handrail use; (3) whether the patient requires a registered nurse to perform services; (4) whether the patient's use of drugs requires daily observation; (5) whether the patient require assistance with activities of daily living, including maintaining Foley catheters, ostomies, special diet supervision, or skin care with incontinent patients; (6) whether the patient has a colostomy-ileostomy; (7) whether the patient requires oxygen therapy; (8) whether the patient requires either radiation or chemotherapy; (9) whether the patient has skin conditions such as decubitus ulcers, minor skin tears, abrasions, or chronic skin conditions; (10) whether the patient is diabetic and needs daily supervision of diet or medications; and (11) whether the patient has behavioral problems such as wandering, verbal disruptions, combativeness, verbal or physical abusiveness, or inappropriate behavior. (Ex. B, p. 43).

V. The Medicaid Home and Community-Based Waiver Services Program – in General.

As stated in 7 AAC 43.1000, "[t]he purpose of 7 AAC 43.1000 - 7 AAC 43.1110 [i.e. the Waiver Services regulations] is to offer a choice between home and community-based waiver services and institutional care in a nursing facility or ICF/MR to aged, blind, physically or developmentally disabled, or mentally retarded individuals who meet the eligibility criteria in 7 AAC 43.1010."

An adult between the ages of 21 and 65 who has physical disabilities is entitled to receive Medicaid Home and Community-Based Waiver Services if the person requires "a level of care provided in a nursing facility." 7 AAC 43.1010(d)(1)(B) and (d)(2). However, pursuant to 7 AAC 43.1010(b), "[h]ome and community-based waiver services are not available to an individual . . . (2) if the individual's need for home and community-based services, supports, devices, or supplies may be

[16] The *Manual for Prior Authorization of Long Term Care Services* is applicable to *both* the non-waiver LOC determination *and* the HCBW LOC determination.

provided for entirely under 7 AAC 43.100 - 7 AAC 43.942" (which regulations include Personal Care Services and Home Care Services). [17]

VI. Regulations Relevant to Choice Waiver / HCBW Level-of-Care Determinations.

Pursuant to 7 AAC 43.1010(d)(2), the Division is required to perform a level of care assessment under 7 AAC 43.1030(b). That regulation, titled "Screening, Assessment, Plan Of Care, And Level Of Care Determination," provides in relevant part as follows:

> (b) If warranted by the screening under (a) of this section and supportive diagnostic documentation, and to determine if the applicant meets the level of care required under 7 AAC 43.1010(d)(2), the department will authorize the care coordinator to prepare a complete assessment of the applicant's physical, emotional, and cognitive functioning and need for care and services. If the assessment is to determine if the applicant falls within the recipient category for . . . (2) adults with physical disabilities or older adults, the (A) department will make a determination to determine whether the applicant requires skilled care under 7 AAC 43.180 or intermediate care under 7 AAC 43.185; and (B) [the] level of care determination under (A) of this paragraph must incorporate the results of the department's *Consumer Assessment Tool (CAT)* . . . .

The other regulations relevant to HCBW level-of-care determinations are 7 AAC 43.1110 (10), 7 AAC 43.180, 7 AAC 43.185, and 7 AAC 43.190. 7 AAC 43.1110 (10) states in relevant part that "nursing facility" means a facility certified under 7 AAC 43.170 - 7 AAC 43.280 to provide services as a skilled nursing facility (SNF) or as an intermediate care facility (ICF) . . . ". 7 AAC 43.180, 7 AAC 43.185, and 7 AAC 43.190 were previously set forth at pages 10-11, above.

VII. The Consumer Assessment Tool (CAT).

The Consumer Assessment Tool (CAT), referenced in 7 AAC 43.1030(b)(2)(B), is one test or factor used to determine whether an applicant requires either skilled care or intermediate care under the HCBW services program. The CAT performs this determination by assessing an applicant's needs for professional nursing services, for therapy provided by a qualified therapist, for special treatments (chemotherapy, radiation therapy, hemodialysis, peritoneal dialysis), and whether or not an applicant experiences impaired cognition or problem behaviors (Ex. E). Each assessed items is given a numerical score (Ex. E). The CAT assessment "covers the last 7 days and considers other health, medical, or functional needs since the last assessment and/or the previous 12 months" CAT at p. 2 (Ex. E-2).

The CAT also assesses the degree of assistance an applicant requires for activities of daily living (ADLs), which specifically include bed mobility (moving within a bed), transfers (i.e. moving from the bed to a chair, or a couch, etc.), locomotion (walking), eating, and toilet use, which includes

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[17] At the time of the Claimant's assessment on September 29, 2009, and at the time of the Division's notifications of adverse action during the period September – November 2009, the State of Alaska's Home and Community-Based Waiver Services Program was governed by regulations then set forth at 7 AAC 43.990 through 7 AAC 43.1110. However, on February 1, 2010 these regulations were repealed and reenacted (with changes) at 7 AAC 130.100 – 7 AAC 130.319.

Because the Claimant's application was filed, and because the Division's notifications of adverse action were sent, *prior to* the effective date of the "new" regulations, and because the "old" regulations were still in effect at these times, the "old" version of Alaska's Home and Community-Based Waiver Services Program regulations will be applied in this case.

transferring on and off the toilet (Ex. E, p.18). The degree of assistance required is quantified using self-performance codes and support codes as explained below:

The *self-performance codes* rate how capable a person is of performing a particular ADL (Ex. E, p.18):

0 Independent, no help/oversight, or help/oversight provided two times or less during the last seven days.

1 Supervision, which consists of encouragement/oversight/encouragement provided three or more times during the last seven days plus non-weight bearing physical assistance provided one or two times during the last seven days.

2 Limited Assistance, which consists of non-weight bearing physical assistance three or more times during the last seven days, or limited assistance plus weight bearing assistance one or two times during the last seven days.

3 Extensive Assistance, which consists of weight bearing support three or more times during the past seven days, or the caregiver provides complete performance of the activity during a portion of the past seven days.

4 Total Dependence, which consists of the caregiver performing the activity for the applicant during the entire previous seven day period.

5 Cueing, which is spoken instruction or physical guidance for a particular activity required seven days per week.

8 Activity did not occur during the previous seven days.

The *support codes* rate the amount of assistance a person receives for each ADL (Ex. E, p.18):

0 None.
1 Setup assistance only.
2 One person physical assistance.
3 Physical assistance from two or more people.
5 Cueing required seven days per week.
8 Activity did not occur during the previous seven days.

The results of the nursing facility assessment portion of the CAT are then scored (Ex. E p. 29). If an applicant's score is 3 or higher, then the CAT instructs that the applicant "appears to be medically eligible for [a nursing facility] level of care" (Ex. E, p. 29).

In determining an applicant's required level of care for purposes of the Choice Waiver / HCBW services program, the Division is required to consider, *in addition to the applicant's CAT score*, the factors contained in the Criteria for Placement section of the *Manual for Prior Authorization of Long Term Care Services*. *See* 7 AAC 43.190, above. The division is to "make the final level-of-care decision based upon that evaluation." *Id.*

VIII. Case Law Relevant to HCBW Level-of–Care Determination.

In *Bogie v. State, Division of Senior and Disabilities Services*, Superior Court Case No. 3AN-05-10936 (Decision dated August 22, 2006), the court emphasized that a level-of-care determination may not be made solely on an applicant's CAT score, but must also consider the Manual factors and the testimony of the applicant's treating physician. Similarly, in *Casey v. State, Dept. of Health & Social Services, Division of Senior and Disabilities Services*, Superior Court Case No. 3AN-06-6613 (Decision dated July 11, 2007), the court stated that although the level-of-care determination must incorporate the results of the CAT, "[t]he Division must make its final level-of-care decision" based on the guidelines established in the *Manual*.

ANALYSIS

Introduction: Definition of Issues; Burden of Proof.

This case involves two separate matters which were consolidated for hearing and decision. The first matter involves the Division's decision to cease (terminate) payment for the Claimant's stay at the [redacted] Medical Center Long-Term Care Facility. This decision was made *outside the Choice Waiver Program* pursuant to 7 AAC 43.005, 7 AAC 43.170, 7 AAC 43.210, and 7 AAC 43.270.

The second matter involves the Division's denial of the Claimant's subsequent application for Choice Waiver services. This decision was made *inside the Choice Waiver Program* pursuant to 7 AAC 43.1010(d)(2) and 7 AAC 43.1030(b).

The decision to terminate Medicaid payment for the Claimant's long-term care, and the decision denying eligibility for Choice Waiver / HCBW services, involve the same primary issue: whether the Claimant required either skilled or intermediate level nursing care. [18] However, *the precise methodology for determining level-of-care varies between the waiver and non-waiver programs*. The difference is that *the Choice Waiver regulations require consideration of the Claimant's CAT score, while the "non-waiver" program's level of care regulations do not. See* Principles of Law at pages 10-16, above. Accordingly, the analyses of level-of-care under the two programs is slightly different and must be presented separately for purposes of clarity. In addition, the burdens of proof differ between the two programs (*see* Principles of Law at pp. 9-10, above).

The parties' arguments are essentially the same with regard to both programs at issue.

The arguments asserted by the Claimant can fairly be summarized as follows:

> 1. The Claimant requires an intermediate level-of-care pursuant to 7 AAC 43.185 (1) because his diabetes and other medications and dietary needs "require the daily observation of a nurse to ensure his safety," and (2) because of his behavioral problems. Claimant's Pre-Hearing Brief of December 21, 2009 at 3.

[18] The Claimant did not assert that he required an Assisted Living level-of-care as defined in 7 AAC 47.300- 47.310. Accordingly, this case *does not involve* the issue of whether the Claimant requires an Assisted Living level-of-care at an Assisted Living Facility (ALF) or assisted living home. Assisted living homes provide nonmedical residential care. 7 AAC 47.300. This "includes more than housing and food service, but does not include continuous nursing or medical care." 7 AAC 47.310. "Assisted living care encompasses 24-hour supportive and protective services of daily living and in the instrumental activities of daily living . . . ". 7 AAC 47.310.

2. "Inability to properly administer medication would require nursing services. Administration of medication in Alaska is a nursing service." Claimant's Post-Hearing Brief of July 16, 2010 at 7.

The arguments asserted by the Division can fairly be summarized as follows:

1. "The fact that [the Claimant] could not manage his own personal care and medication at home does not equate to [a] need for nursing services . . . ." Division's Post-Hearing Brief of July 16, 2010 at 4.

2. The Claimant "does need supervision, just not at the level of nursing facility care." Division's Post-Hearing Brief of July 16, 2010 at 17.

Thus, the parties' primary focus is on (1) whether the Claimant requires an intermediate level-of-care to properly manage his medications; and (2) whether the Claimant requires an intermediate level-of-care to properly manage his behavioral problems. These two issues will be examined separately in the context of both the non-waiver and the waiver programs.

The matter involving the Division's decision to cease (terminate) payment for the Claimant's stay at the [redacted] Medical Center LTC Facility will be discussed first. The matter involving the Division's denial of the Claimant's subsequent application for Choice Waiver services will be discussed second.

In the first matter (involving the Division's September 14, 2009 decision to cease (terminate) payment for the Claimant's stay at the [redacted] Medical Center Long-Term Care Facility), the Division is the party seeking to change the status quo and therefore bears the burden of proof. In the second matter (involving the Division's November 5, 2009 denial of the Claimant's subsequent application for Choice Waiver services), the Claimant is the party seeking to change the status quo and therefore bears the burden of proof.

I. Was The Division Correct to Terminate Medicaid Coverage For The Claimant's Stay At The [redacted] Medical Center Long-Term Care Facility Based on The Assertion That The Claimant Did Not Require Either Skilled or Intermediate Level Nursing Care?

As noted above, in this matter the Division is the party seeking to change the status quo by terminating payment for the Claimant's stay at the [redacted] Medical Center Long-Term Care Facility. Accordingly, the Division bears the burden of proof with regard to this matter.

As discussed in the Introduction, the Claimant's CAT scores are not relevant to the Division's decision terminating Medicaid coverage for the Claimant's residence at the [redacted] LTC Facility. Rather, the relevant standards are those set forth in 7 AAC 43.180, 7 AAC 43.185, 7 AAC 43.190, and the *Manual for Prior Authorization of Long Term Care Services* (Exs. B-39 through B-43).

The regulation pertaining to the skilled level-of-care (7 AAC 43.180), and the regulation pertaining to the intermediate level-of-care (7 AAC 43.185) both contain broad statements concerning their respective level-of-care determinations (see text of regulations in Principles of law, above). However, 7 AAC 43.190 specifically instructs the Division to "make [its] level-of-care evaluation in accordance with the guidelines established in the Criteria for Placement section of the *Manual for Prior*

Authorization of Long Term Care Services. Accordingly, it is apparent that the specific requirements of the *Manual* carry the greatest weight in making the level-of-care determination.

A. Analysis of the Skilled Level-of-Care Nursing Factors.

The record indicates that the *Manual* factors by which the Claimant might potentially qualify for a *skilled level of nursing care* are as follows (see Exs. B-40 through B-42):

1. Medication management (for the Claimant's diabetes). The Claimant was taking insulin on a sliding scale for a few days in September 2009 ([redacted]). However, at other times he was able to administer his own insulin ([redacted]). As long as the Claimant is on a standard dose of insulin (and not on a sliding scale), his insulin could be managed without skilled nursing care at an Assisted Living Facility (ALF) ([redacted] testimony). Accordingly, the Claimant does not meet this factor.

2. The need for sterile dressings (with regard to his toe ulcer / lesion). Pursuant to the *Manual*, this factor only indicates a need for skilled nursing care where the dressing "require[es] prescription medication" (Ex. B-41). There is evidence in the record that the Claimant's toe ulcer required several courses of antibiotics (Ex. E-2). Accordingly, the Claimant meets this factor by a preponderance of the evidence.

3. The ulcer on the Claimant's toe. Pursuant to the *Manual*, this factor only indicates a need for skilled nursing care where the ulcer is a decubitus ulcer which is either infected or extensive (Ex. B-41). Although there is evidence in the record that the Claimant's toe ulcer was infected, there is no evidence that it was a decubitus ulcer. [19] Accordingly, the Claimant does not meet this factor.

4. The Claimant's diabetes. Pursuant to the *Manual*, this factor only indicates a need for skilled care when the diabetes is uncontrolled (Ex. B-41). The Claimant's diabetes clearly requires high doses of insulin (Ex. 1 pp 24-26), but there is no evidence in the record indicating that his diabetes is uncontrolled. Accordingly, the Claimant does not meet this factor.

5. Behavioral problems. There was no dispute that the Claimant sometimes has behavioral problems. However, pursuant to the *Manual*, the only behavioral problems which can be considered are those behavioral problems which require "treatment or observation by the skilled nursing personnel" (Ex. B-42). There is no evidence in the record indicating that the Claimant's behavioral problems require treatment or observation by skilled nursing personnel. Accordingly, the Claimant does not meet this factor.

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[19] A decubitus ulcer is basically a pressure ulcer or bed sore caused by prolonged pressure on the affected part of the body. *See* Princeton University's online dictionary at http://wordnetweb.princeton. edu/perl/webwn?s=decubitus%20ulcer (date accessed October 4, 2010). The bony prominences of the body are the most frequently affected sites. *See* Webster's Online Dictionary at http://www.websters-online-dictionary.org/definitions/Decubitus?cx=partner-pub-0939450753529744%3Av0qd01-lq&cof=FORID%3A9&ie=UTF-8&q=Decubitus&sa=Search#922 (date accessed October 4, 2010). The ulcer is caused by ischemia (deficient supply of blood due to obstruction of the inflow of arterial blood) of the underlying structures of the skin, fat, and muscles as a result of the sustained and constant pressure. *Id.*

B. Analysis of the Intermediate Level of Care Factors.

The record indicates that the *Manual* factors by which the Claimant might potentially qualify for an *intermediate level of nursing care* are as follows (Exs. B-42, B-43):

1. Medication management (for the Claimant's diabetes). Pursuant to the *Manual*, this factor only indicates a need for intermediate-level care when the medication requires "daily observation for drug effectiveness and side affects" (Ex. B-43). Dr. [redacted] testified that she was not sure whether care by non-nursing staff would be sufficient because of the Claimant's need for insulin and the possibility of a hypoglycemic reaction ([redacted] testimony). However, the *Manual* states that "[a]dmission to intermediate care will not be authorized solely to provide supervision, protective custody, *routine medication management*, or assistance with personal services" (Ex. B-42). Accordingly, the Claimant does not meet this factor.

2. Assistance with activities of daily living (ADLs). There is evidence in the record indicating that the Claimant requires assistance with his *Daily Instrumental Activities* and *Instrumental Activities of Daily Living* (IADLs) [20] (Ex. E-12). However, IADLs are not the same as *Activities of Daily Living* (ADLs). [21] There was scant evidence in the record to indicate that the Claimant required assistance with his *Activities of Daily Living* (ADLs).

Further, the *Manual* states that "[a]dmission to intermediate care will not be authorized solely to provide supervision, protective custody, routine medication management, *or assistance with personal services*" (Ex. B-42). Accordingly, even if the Claimant requires assistance with his ADLs, this factor alone would not qualify him for an intermediate level-of-care.

3. Skin conditions. Pursuant to the *Manual*, this factor indicates a need for intermediate level nursing care in two situations: (a) when the skin condition is a decubitus ulcer; or (b) when the problem is a minor skin tear, abrasion, or chronic skin condition "requiring daily observation and/or intervention by licensed personnel" (Ex. B-43).

The Claimant had an open wound on his toe at the time of his assessment ([redacted] testimony). The Claimant had this wound at least since September 1, 2009 and had received care for it from a doctor (Ex. 1 p. 24). Given the length of time that the Claimant had this wound, the fact that he had seen a doctor about it, and the fact that the nursing staff would necessarily have been regularly checking the wound and changing the dressing (see Ex. 1 p. 24), it is more probable than not that the Claimant satisfied this *Manual* factor.

4. Diabetes. Pursuant to the *Manual*, this factor indicates a need for intermediate-level nursing care "when daily observation of dietary intake and/or medication administration is required for proper physiological control" (Ex. B-43). In this case, the Claimant was only taking insulin on a sliding scale for a few days in September 2009 ([redacted] testimony), and at other times he was able to administer his own insulin ([redacted] testimony). As long as the

[20] Pursuant to AS § 47.33.990(11), "instrumental activities of daily living" means "doing laundry, cleaning of living areas, food preparation, managing money and conducting business affairs, using public transportation, writing letters, obtaining appointments, using the telephone, and engaging in recreational or leisure activities."

[21] Pursuant to AS § 47.33.990(1), "activities of daily living" means "walking, eating, dressing, bathing, toileting, and transfer between a bed and a chair."

Claimant is on a standard dose of insulin (and not on a sliding scale), his insulin could be managed without skilled nursing care at an Assisted Living Facility ([redacted] testimony). Further, the *Manual* states that "[a]dmission to intermediate care will not be authorized solely to provide *supervision*, protective custody, *routine medication management*, or assistance with personal services" (Ex. B-42). Accordingly, the Claimant does not meet this factor.

5. Behavioral problems. Pursuant to the *Manual*, "[b]ehavioral problems such as . . . verbal disruptiveness, combativeness, verbal or physical abusiveness, [and/or] inappropriate behavior" indicate a need for intermediate-level nursing care "when these can properly be managed in an intermediate care facility (Ex. B-43).

There was no dispute that the Claimant sometimes has behavioral problems. However, the testimony of Ms. [redacted], Dr. [redacted], Ms. [redacted], and Ms. [redacted] all indicated that the Claimant's behavioral problems could be adequately managed in an Assisted Living Facility (*see* Findings of Fact at Paragraphs 4, 14, 19, and 20). Accordingly, the Claimant does not meet this factor.

C. The Claimant Does Not Require Skilled or Intermediate Level Nursing Care Based on the *Manual* Factors.

As indicated above, the Claimant satisfied one (1) of the 13 *Manual* factors indicating a need for *skilled nursing* care (see sub-section A, above), and one (1) of the 11 *Manual* factors indicating a need for *intermediate-level nursing* care (see sub-section B, above). Thus, the Claimant satisfied approximately 8% of the *skilled* nursing care factors and 9% of the *intermediate* nursing care factors.

Neither the *Manual* nor 7 AAC 43.190 ("Determination of Level-of-Care") state a specific number of factors that an applicant needs to satisfy in order to meet a nursing facility level-of-care. Ms. [redacted] (an R.N.), Ms. [redacted] (an M.S.W.), and Dr. [redacted], all agreed that the Claimant's needs could be met by placement in an *Assisted Living Facility;* their only concern was that the Claimant not be *discharged home alone without adequate supports* (see Findings of Fact at Paragraphs 4, 7, 14, 15, 16, 17, 18, and 20, above). However, as previously stated, the Claimant did not assert that he required an Assisted Living level-of-care as defined in 7 AAC 47.300- 47.310.

In summary, [redacted] LTC facility provides *skilled* and *intermediate-level nursing* care ([redacted] and [redacted] testimony). However, the Claimant satisfied only about 9% of the *Manual* factors indicating a need for *intermediate-level* nursing care, and approximately 8% of the *skilled-level* nursing care factors. In addition, the medical witnesses who opined on the matter all agreed that the Claimant's needs could be met at an Assisted Living Facility (i.e. at a lower-than-intermediate level-of-care). Accordingly, the Division's September 14, 2009 decision to terminate Medicaid authorization for the Claimant's care at the [redacted] Medical Center Long-Term Care Facility (effective October 14, 2009), based on the assertion that the Claimant did not require either *skilled or intermediate-level nursing care,* was clearly supported by a preponderance of the evidence.

II. Was The Division Correct When on November 5, 2009 it Denied The Claimant's September 2009 Application For Medicaid Home And Community-Based Waiver Services Based On The Assertion That The Claimant Did Not Require Either Skilled or Intermediate Level Nursing Care?

The level-of-care analysis for the HCBW Program is based on 7 AAC 43.1030(b) and on the judicial decisions interpreting that regulation. 7 AAC 43.1030(b) states in relevant part that the "level-of-care determination . . . must incorporate the results of [the] *Consumer Assessment Tool (CAT)* . . ."

By itself, 7 AAC 43.1030(b) does not require that the Division consider any information other than a claimant's CAT score when making an HCBW level-of-care determination. However, in *Bogie v. State, Division of Senior and Disabilities Services*, Superior Court Case No. 3AN-05-10936 (Decision dated August 22, 2006), and in *Casey v. State, Dept. of Health & Social Services, Division of Senior and Disabilities Services*, Superior Court Case No. 3AN-06-6613 (Decision dated July 11, 2007), the Alaska Superior Courts emphasized that a level-of-care determination may not be made *solely* on an applicant's CAT score, but must *also* consider the *Manual* factors and the testimony of the applicant's treating physician (*see* Principles of Law, above). [22]

Accordingly, in the following analysis, this decision will first examine, pursuant to 7 AAC 43.1010(d)(2) and 7 AAC 43.1030(b), whether the Claimant's CAT was scored appropriately. The decision then examine whether the *Manual* factors were correctly applied. [23] Because the HCBW application case involves an initial application, the Claimant bears the burden of proof on all factual issues by a preponderance of the evidence (*see* Principles of Law at p. 9, above).

A. Do CAT Scoring Errors Exist Which Would Change the Claimant's LOC Assessment?

As discussed above, the *Consumer Assessment Tool* or CAT is the first part of the two-part test used to determine whether an applicant requires either skilled care or intermediate care. 7 AAC 43.1030(b)(2)(B). Eligibility for HCBW services is therefore based, in the first instance, on the CAT; the *Manual* factors are analyzed last.

The only CAT scoring areas which were seriously challenged by the Claimant were with regard to (1) medication management / self-administration of insulin; and (2) the Claimant's behavioral problems (*see* Claimant's Post-hearing Brief dated July 16, 2010 at pp. 7-11) These areas are discussed below.

1. Medication Management / Self-Administration Of Insulin.

In her assessment of September 29, 2009, Ms. [redacted] recorded the following findings relevant to medication management issues(Ex. E-2):

> Vital signs / diabetic testing: according to staff and client, [Claimant] independently does his BS testing bid, self-administers insulin; compliance likely a problem without supervision, but functionally [Claimant] is able to manage this task.

* * * * * * * * * * *

[22] The Division asserts that "[t]he Manual itself has no value for waiver decisions apart from the CAT assessment." Division's Post-Hearing Brief of July 16, 2010 at 14. However, as indicated by the *Bogie* and *Casey* Superior Court decisions, this is not correct.

[23] The testimony of the Claimant's treating physician will be considered, along with other relevant evidence, at both the first level (CAT scoring) and second level (*Manual* factors) of the two-tiered LOC analysis.

> Medication: [Claimant] able to swallow easily. Takes meds with water or milk or hot chocolate . . . .

Based on her findings Ms. [redacted] gave the Claimant a medication preparation / administration score of 1 ("person prepared and administered some of his/her own medications" in the last 7 days), and a medication compliance code of 0 ("person always compliant" within the last 7 days) (Ex. E-8).

At the hearing there was credible testimony that the Claimant was not always self-administering his insulin at the time of the assessment, and that he was not always compliant in taking his insulin and other medications (*see* Findings of Fact at Paragraphs 16, 18, and 19). Accordingly, it is more probable than not that the Claimant's compliance score should have been a "1" ("compliant some of the time") rather than a zero.

The next question is whether changing the Claimant's medication score as indicated above would change his ultimate CAT score. Review of the CAT indicates that it would not. First, the scores in the medication section of the CAT (Section G) do not transfer directly into the final eligibility determination scoring sheet (Ex. E-14). The change in the medication score would only effect the final CAT score if the administration of medication involved professional nursing services (Ex. E-14 at Section A). Because the Claimant was generally on a standard dose of insulin (and not on a sliding scale), his insulin could be managed without skilled nursing care at an Assisted Living Facility (ALF) ([redacted] testimony). Accordingly, any mis-scoring of the Claimant's CAT in the medication category could not have affected the Claimant's ultimate CAT score.

2. Behavioral Problems.

In her assessment of September 29, 2009, Ms. [redacted] recorded the following findings relevant to the Claimant's behavior (Ex. E-1): "Behaviors / Cognition: . . . . No reported untoward behaviors." Based on her findings Ms. [redacted] gave the Claimant scores of zero in the "Problem Behavior" section of the CAT (Section D, items 2a and 3). *See* Ex. E-5. These scores indicate a finding that the Claimant did not require professional nursing assessment, observation, and management three (3) or more days per week (item 2a), or even once per month (item 3), to manage his behavior problems.

The record contains credible evidence that the Claimant had behavioral problems (Ex. 2.1; [redacted] testimony). However, under the CAT, behavior problems *only receive a score if they require professional nursing services* (*see* Section D, items 2a and 3, at Ex. E-5; *see also* [redacted] testimony). Although there is evidence in the record to suggest that the Claimant's problem behaviors required intervention, there is no evidence to suggest that the problem behaviors required intervention by professional nursing staff. Accordingly, even though the reports received by Ms. [redacted] that the Claimant had no "untoward behaviors" may not have been entirely correct, this could not have affected the Claimant's ultimate CAT score.

3. Summary.

In summary, the Claimant failed to prove, by a preponderance of the evidence, that there was any error with regard to the Division's scoring of his CAT that would have increased his ultimate CAT score and/or made him eligible for HCBW services. The next (and last) step in the HCBW level-of-care analysis is to determine whether the *Manual* factors were correctly applied by the Division.

B. Did The Division Properly Apply The *Manual* Factors in Denying HCBW Services?

Pursuant to 7 AAC 43.1030(b)(2)(B), the Division's "level-of-care determination . . . must *incorporate* the results of the department's *Consumer Assessment Tool (CAT)"* [emphasis added]. The Claimant failed to qualify for HCBW Services based on his CAT scores, as discussed above. However, this does not end the inquiry. Next, pursuant to 7 AAC 43.190, the "division [must] make the *final* level-of-care decision based upon" the "guidelines established in the Criteria for Placement section of the *Manual for Prior Authorization of Long-Term Care Services* . . . . [emphasis added].

[redacted], a registered nurse employed by the Division, reviewed the September 29, 2009 assessment and compared it to the factors listed in the State of Alaska *Manual for Prior Authorization of Long-Term Care Services* in order to determine whether the Claimant qualified for HCBW Program services (Exs. D-7, D-8). Ms. [redacted] did not find any factors indicating that the Claimant required a skilled or intermediate-level of nursing care (Exs. D-7, D-8). Accordingly, she determined that the Claimant did not meet LOC as of the date of her assessment (*see* Findings of Fact at Paragraph 15).[24]

A review of the *Manual for Prior Authorization of Long-Term Care Services* demonstrates that the only *skilled* level-of-care factors that could have potentially qualified the Claimant for HCBW Services, as of his September 29, 2009 assessment, were (1) medication management (for the Claimant's diabetes); (2) the need for sterile dressings (with regard to his toe ulcer / lesion); (3) his skin conditions; (4) the Claimant's diabetes; and/or (5) the Claimant's behavioral problems. As demonstrated in Section I (A, C) at pages 18-20, above, the Claimant satisfied only one (1) of the *Manual* factors indicating a need for skilled nursing care (i.e. the need for sterile dressings).

Similarly, a review of the *Manual for Prior Authorization of Long-Term Care Services* demonstrates that the only *intermediate* level-of-care factors that could have potentially qualified the Claimant for HCBW Services, as of his September 29, 2009 assessment, (1) medication management (for the Claimant's diabetes); (2) assistance with the Claimant's activities of daily living (ADLs); (3) the Claimant's skin conditions; (4) the Claimant's diabetes; and/or (5) the Claimant's behavioral problems. As demonstrated in Section I (B, C) at pages 19-20, above, the Claimant satisfied only one (1) of the *Manual* factors indicating a need for intermediate-level nursing care (with regard to the toe lesion).

As discussed in Section I (C), above, neither the *Manual* nor 7 AAC 43.190 ("Determination of Level of Care") state a specific number of factors that an applicant needs to satisfy in order to meet level-of-care. However, Ms. [redacted] (an R.N.), Ms. [redacted] (an M.S.W.), and Dr. [redacted], *all agreed that the Claimant's needs could be met by placement in an Assisted Living Facility* [25] (*see* Findings of Fact at Paragraphs 4, 7, 14, 15, 18, and 21, above). The primary concern of the Claimant's medical witnesses was *not* that the care administered at an ALF would be insufficient, but rather that the

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[24] For reasons not reflected in the record, the Division did not call Ms. [redacted] at hearing to testify in support of her assessment review of November 3, 2009. Instead, the Division called [redacted], R.N., a nurse-assessor with the same job functions and responsibilities as Ms. [redacted] ([redacted] testimony). Ms. [redacted] reviewed the Division's information on the Claimant prior to testifying and then gave her own opinion as to the correctness of the assessment review conducted in this case. *See* Findings of Fact at Paragraphs 21(a-c).

[25] The Claimant did not assert that he required an Assisted Living level-of-care as defined in 7 AAC 47.300 – 47.310 Accordingly, this case *does not involve* the issue of whether the Claimant requires an Assisted Living level-of-care at an Assisted Living Facility (ALF) or assisted living home.

Claimant's health would be in danger *if he were discharged home alone without adequate supports* (see Findings of Fact at Paragraphs 16, 17, and 18).

In summary, the Claimant satisfied a low percentage of those *Manual* factors indicating a need for skilled or intermediate-level nursing care, and the medical witnesses who opined on the matter all agreed that the Claimant's needs could be met at an Assisted Living Facility (i.e. at a lower-than-intermediate level-of-care). [26] Accordingly, the Division was correct when, on November 5, 2009, it denied the Claimant's September 2009 application for Medicaid Home and Community-Based Waiver Services because the Claimant did not require either skilled or intermediate level nursing care.

C. Summary.

In summary, the Claimant had the burden of proof in this case. However, he did not establish that the final score on his September 29, 2009 CAT assessment was incorrect, or that he qualified for HCBW Services based on the *skilled- or intermediate- level nursing care* factors contained in the *Manual for Prior Authorization of Long-Term Care Services.* Accordingly, the Claimant failed to prove, by a preponderance of the evidence, that he required a *skilled or intermediate-level of nursing care*. The Division was therefore correct when on November 5, 2009 it denied the Claimant's application for HCBW Services.

CONCLUSIONS OF LAW

I. September 2009 Termination of Medicaid Authorization.

1. The Division carried its evidentiary burden and proved, by a preponderance of the evidence, that as of September 14, 2009 the Claimant did not require either a *skilled nursing facility* level-of-care pursuant to 7 AAC 43.180, 7 AAC 43.190, and the *Manual* factors, or an *intermediate nursing facility* level of care pursuant to 7 AAC 43.185, 7 AAC 43.190, and the *Manual* factors.

2. Accordingly, the Division was correct when, on September 14, 2009, it notified the Claimant that it would terminate Medicaid nursing home certification / coverage for the Claimant's stay at the [redacted] Medical Center Long-Term Care Facility effective October 14, 2009.

II. November 2009 Denial of Application for HCBW Services.

1. The Claimant failed to carry his evidentiary burden and did not prove, by a preponderance of the evidence, that based on the *Consumer Assessment Tool* (CAT) or the *Manual* factors, he required either a *skilled nursing facility* level-of-care or an *intermediate nursing facility* level-of-care, as of the date of his assessment (September 29, 2009).

2. Accordingly, the Division was correct when, on November 5, 2009, it denied the Claimant's application for participation in the Medicaid Home and Community-Based Waiver Services Program because he did not require a *skilled or intermediate- level of nursing* care.

DECISION

[26] *See* footnote 25, above.

The Division was correct when, on September 14, 2009, it notified the Claimant that it would terminate Medicaid nursing home certification / coverage for the Claimant's stay at the [redacted] Medical Center Long-Term Care Facility effective October 14, 2009.

The Division was also correct when, on November 5, 2009, it denied the Claimant's application for participation in the Medicaid Home and Community-Based Waiver Services Program.

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:

Acting Director, Division of Senior and Disabilities Services
State of Alaska Department of Health and Social Services
550 West 8th Avenue
Anchorage, Alaska 99501

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 12th day of October, 2010.

(signed)

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Jay Durych
Hearing Authority

CERTIFICATE OF SERVICE

I certify that on the 12th day of October 2010 true and correct copies of the foregoing document were sent to the Claimant via U.S.P.S. Mail, as follows:

[redacted], Esq.,
Legal Director, Disability Law Center of Alaska
Counsel for Claimant
Via Certified Mail, Return Receipt Requested

I certify that on the 12th day of October 2010 true and correct copies of the foregoing document were sent to the remainder of the service list by e-mail, as follows:

[redacted], Esq.
Attorney General's Office, Department of Law
Counsel for the Division of Senior and Disabilities Services

[redacted], DHCS / DSDS Hearing Representative

[redacted], Acting Director, DSDS
[redacted], Policy & Program Development

[redacted], Staff Development & Training
[redacted], Eligibility Technician I
(signed)

_____

J. Albert Levitre, Jr.
Law Office Assistant I