Office of Hearings and Appeals
3601 C Street, Suite 1322
P. O. Box 240249
Anchorage, Alaska 99524-0249
Phone (907) 334-2239
Fax (907) 334-2285

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

In the Matter of:	)	
	)	
L T,	)	OHA Case No. 10-FH-172
	)	
Claimant.	)	DPA Case No.
	)	

ORDER GRANTING DIVISION OF PUBLIC ASSISTANCE'S MOTION FOR RECONSIDERATION

I. Introduction.

The Office of Hearings and Appeals (OHA or Office) issued a decision in this case on October 25, 2010. That decision found that the Division of Public Assistance (DPA or Division) had failed to carry its burden and had not proved by a preponderance of the evidence that the Claimant's physician-defined cervical cancer treatment program ended on or before May 12, 2010, the date the Division mailed its termination notice to the Claimant. Accordingly, the decision concluded that, pursuant to 7 AAC 100.710(b), the Division was not correct to terminate the Claimant's participation in the Medicaid Breast and Cervical Cancer Treatment Program after May 31, 2010.

On October 28, 2010 the Division submitted a "rebuttal" to the October 25, 2010 decision. This is considered a motion for reconsideration. The Division's motion indicated that a copy had been mailed to the Claimant. The Claimant did not submit any response to the Division's motion to this Office.

The Alaska Fair Hearing Regulations, 7 AAC 49.010 *et seq.*, do not contain a procedure or requirements for filing motions for reconsideration. However, because motions for reconsideration originated with the courts, this Order will adopt, as a model, the criteria / requirements for reconsideration specified by Alaska Rule of Civil Procedure 77(k)(1). [1]

[1] Alaska Rule of Civil Procedure 77(k)(1) provides as follows:

> (1) A party may move the court to reconsider a ruling previously decided if, in reaching its decision: (i) The court has overlooked, misapplied or failed to consider a statute, decision or principle directly controlling; or (ii) The court has overlooked or misconceived some material fact or proposition of

The Division's motion basically asserts that this Office overlooked or misconceived a material fact or facts. Accordingly, the Division's motion satisfies the requirements of Alaska Rule of Civil Procedure 77(k). It is therefore appropriate to consider the merits of the Division's motion.

II. Relevant Facts and Procedural History.

The Division terminated Medicaid coverage for the Claimant's Breast and Cervical Cancer Prevention and Treatment (BCCPTA) benefits after May 31, 2010 because it determined that Claimant was "no longer in treatment for breast and cervical cancer." The most recent medical report in the record, upon which the Division's determination was based, is a report by Dr. Max Rabinowitz, M.D. dated May 4, 2010. That report states in relevant part as follows:

> Assessment / Plan: (1) Endometrial cancer. She had surgical debulking . . . . She finished chemotherapy in December 2009. She continues to have no evidence of recurrence. She is recovering from chemotherapy quite well. Her performance status continues to improve. At this point *we will have her follow-up in 3 months with a repeat CBC,* [2] *CMP,*[3] *and CA125.* [4] I asked her to call if she has any new symptoms or concerns. (Emphasis added).

The Division's action was appealed to this Office and a decision was issued. The decision issued by this Office held that the Division was not correct to terminate Claimant's participation in the BBCPTA Program because the "evidence shows that on May 4, 2010 Claimant's physician recommended a treatment plan that included a follow up in 3 months and additional testing."

The Division has filed a motion for reconsideration asserting that, as of the Claimant's physician's exam of May 4, 2010 (as documented in the above-quoted report), the Claimant's "treatment" had ended, and she was therefore no longer eligible for the BCCPTA Program.

---

law; or (iii) The court has overlooked or misconceived a material question in the case; or (iv) The law applied in the ruling has been subsequently changed by court decision or statute.

[2] A "CBC is a "complete blood count" counting the number of white and red blood cells and the number of platelets in 1 cubic millimeter of blood. *See* Princeton University's online dictionary at wordnetweb.princeton.edu/perl/webwn (date accessed November 29, 2010).

[3] "CMP" stands for "comprehensive metabolic panel." *See* Medline Plus, an online service of the U.S. National Library of Medicine and the National Institutes of Health, at http://www.nlm.nih.gov/medlineplus/ency/article/003468.htm (date accessed November 29, 2010). CMP is a group of chemical tests performed on the blood serum (the part of blood that doesn't contain cells). *Id.* These tests include total cholesterol, total protein, and various electrolytes. *Id.*

[4] CA stands for "cancer antigen." CA 125 is a protein that is a so-called tumor marker, which is a substance that is found in greater concentration in tumor cells than in other cells of the body. The most common use of the CA 125 test is the monitoring of women with known ovarian cancer. *Id.* A decreasing level of CA 125 generally indicates that therapy has been effective, while an increasing level of CA 125 indicates tumor recurrence. *Id. See* online article by Melissa Conrad Stoppler, M.D. at http://www.medicinenet.com/ca_125/article.htmIn (date accessed November 29, 2010).

III. The Breast and Cervical Cancer Treatment Program – Relevant Regulation.

The Claimant's eligibility for continuing treatment pursuant to the federal Breast and Cervical Cancer Prevention and Treatment Act ("BCCPTA") [5] is governed by 7 AAC 100.710. That regulation 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;
>
> * * * * * * * * * * * *
>
> (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]. [6]
>
> * * * * * * * * * * * *

Thus, pursuant to the above regulation, 7 AAC 100.710(b), a woman remains eligible during the period that the woman is *receiving treatment*, and is presumed to be receiving treatment during the duration of the *treatment plan* established by her physician.

IV. Issue.

The central point of the Division's motion for reconsideration is the assertion that, as of the Claimant's physician's exam of May 4, 2010 (as documented in the above-quoted report), the Claimant's "treatment" had ended, and she was therefore no longer eligible for the program. Accordingly, the issue can best be stated as:

> Are the three diagnostic tests ordered by Claimant's physician (i.e. the CBC, CMP and CA125) best characterized as "treatment," and/or were they part of the "treatment plan?" Or, on the other hand, are they best characterized as surveillance, follow-up, or maintenance?

---

[5] The federal implementing statutes are 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVIII); § 1396(a)(xiii); § 1396a(aa); and § 1396a(a)(10(G)(XIV).

[6] Section 575D of the Division's "Aged, Disabled and Long Term Care Medicaid Eligibility Manual" essentially mirrors 7 AAC 100.710(b) and provides in relevant part that "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 . . . . When her *treatment* ends, her Medicaid eligibility under this category also ends" [italics added].

V. Analysis.

As stated previously, the central point of the Division's motion for reconsideration is the assertion that, as of the Claimant's physician's exam of May 4, 2010 (Exs. 11.23-11.24), the Claimant's "treatment" had ended. The terms "receiving treatment" and "treatment plan" are not defined in either 7 AAC 100.710 or in the Breast and Cervical Cancer program's definitional section (7 AAC 100.990). Accordingly, it is appropriate to look to other sources for guidance.

A. The *Hauser* Decision.

The October 25, 2010 decision in this case cited *Hauser v. Idaho Department of Health and Welfare*, 2004 WL 1854250 (Idaho Dist. Ct. 2004), a case involving the interpretation of Idaho's version of 7 AAC 100.710(b), the regulation at issue here. In *Hauser*, (as in this case), the claimant, after receiving treatment, no longer had any detectable evidence of cancer. Because of this, the Idaho agency asserted (among other points) that Ms. Hauser no longer required treatment because she had no detectable evidence of cancer. *Id.* Ms. Hauser was, however, receiving long-term drug therapy. *Id.* She 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 *Hauser* 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 cancer. *Id.* The court ruled that Claimant was eligible for treatment under BCCPTA because "she requires hormone therapy" and this treatment is standard protocol for women with hormone receptive positive breast cancer (*Hauser* at p.11). The *Hauser* court remanded the case to the Idaho state agency and ordered that the claimant's BCCPTA coverage be reinstated. *Id.*

B. Basis for the *Hauser* Court's Decision.

The *Hauser* court stated that, in considering whether the Idaho regulation was consistent with BCCPTA, the following should be examined: "(1) the words of the statutory provisions themselves, and (2) the 'technical guidance' provided by the federal agency on its internet homepage" (*Hauser* at p.5).

1. The Relevant Medicaid Statutes.

The two relevant federal statutory provisions of the BBCPTA, both cited by the *Hauser* court, are 42 U.S.C. 1396(aa) and 42 USC 1396(a)(10)(G)(XIV). The first provision cited, 42 U.S.C. 1396(aa), states in pertinent part that, to be eligible, an individual "*must need treatment for breast or cervical cancer . . . .*" The second statutory provision cited, 42 USC 1396(a)(10)(G)(XIV), states that Medicaid eligibility for individuals qualifying for the program "shall be limited to medical assistance provided during the period in which such *an individual requires treatment* for breast or cervical cancer. (Emphasis added in the *Hauser* court's decision at p.5).

2. Policy Statements by the Centers for Medicare and Medicaid Services.

The *Hauser* court also considered policy statements provided by the Centers for Medicare and Medicaid Services ("CMS"). [7] The *Hauser* decision sets forth the following "technical guidance" provided by CMS:

> The term "need treatment" means that, a CDC breast or cervical cancer screen indicates that the woman is in need of cancer treatment services. These services include diagnostic services that may be necessary *to determine the extent and proper course of treatment*, [emphasis added] as well as definitive *cancer* treatment itself. [Emphasis added by the court]. Women who are determined to require only routine monitoring services for a precancerous breast or cervical condition (e.g., breast examinations and mammograms) are not considered to need treatment.

Hauser at p.6. (copy of current CMS guidance attached as Ex. 1).

The *Hauser* decision adopts the CMS guidance with regard to the term "need treatment". The CMS guidance states that diagnostic services are covered, but they must relate to a "definitive cancer treatment", *after* a cancer screen indicates that the woman has cancer. In this circumstance, diagnostic services "may be necessary to determine the extent and proper course of treatment." *See* CMS guidance above. The *Hauser* court concludes, however, that this term "does not include routine monitoring for *precancerous conditions*" (*Hauser* decision at p.6; emphasis in the court's decision). The *Hauser* decision makes clear that there is no eligibility if the procedures or tests are for surveillance, follow-up or maintenance (*Hauser* decision at p.5).

C. Factual Similarities Between This Case and *Hauser*.

There are a several similarities between this case and Hauser. Both Ms. Hauser and the Claimant had cancer and were treated with surgery and chemotherapy. Both were cancer–free at the time their state agency terminated their benefits.

D. Factual Differences Between This Case and *Hauser*.

There are, however, also several factual distinctions between this case and *Hauser*:

In *Hauser*, the claimant's physician testified that Ms. Hauser remained in active treatment for her breast cancer because of her pharmaceutical therapy with Femara; that she was not merely undergoing "routine monitoring for a pre-cancerous condition;" and that she was not merely in a "surveillance, follow-up or maintenance mode" (*Hauser* at p.7). The *Hauser* decision summarizes the testimony of Ms. Hauser's physician as follows:

> Dr. Grosset states that the current standard practice for Femara therapy is to administer a five (5) year course of treatment involving daily medication and close monitoring by a physician. He further states that this is the "optimal standard" of

[7] CMS is the federal agency which administers the Medicare, Medicaid, and Children's Health Insurance programs. Prior to June 14, 2001 CMS was known as the Health Care Financing Administration or "HCFA." *See* http://findarticles.com/p/articles/mi_m3257/is_8_55/ai_78363222/ (date accessed January 14, 2011).

> practice – the "gold standard" of care for women, such as Ms. Hauser, with "hormone receptor positive breast cancer." According to Dr. Gosset, it would be a "clear dereliction of a health care provider's duty of care" if such women were not offered this treatment . . . . Dr. Gosset states "unequivocally" that Ms. Hauser remains in active treatment for her breast cancer. [Emphasis added by the court].

By contrast, in this case the most relevant physician note states that the Claimant "is recovering from chemotherapy quite well," that "[h]er performance status continues to improve," that she "continues to have no evidence of recurrence," and that "we will have her follow-up in 3 months with a repeat CBC, CMP and CA125" (Ex. 11.24). In other words, at the time the Claimant's physician wrote the foregoing notes, the Claimant was cancer-free, and there is no evidence in the record that the Claimant is undergoing pharmaceutical therapy as was the case in *Hauser*.

E. There are More Differences Than Similarities Between This Case and *Hauser*.

As demonstrated in subsection (D), above, there are significant differences between this case and *Hauser*. Per the CMS policy statements quoted in *Hauser* at p.6., "[w]omen who are determined to require only routine monitoring services for a precancerous breast or cervical condition . . . are not considered to need treatment." Here, unlike the claimant in the *Hauser* decision, there is no evidence that the Claimant is undergoing pharmaceutical (or other) therapy, or that the tests in question are part of a "definitive cancer treatment" Rather, the diagnostic tests ordered by the Claimant's physician were ordered to monitor and follow up on her cancer-free status. As such, the Claimant's tests constitute "routine monitoring for precancerous conditions."

VI. Summary and Conclusion.

Pursuant to 42 U.S.C. 1396(aa) and 42 USC 1396(a)(10)(G)(XIV), a woman is eligible for BBCPTA coverage if she "*need[s] treatment for breast or cervical cancer"* or "*requires treatment"* for breast or cervical cancer. Similarly, pursuant to 7 AAC 100.710(b), a woman who is otherwise eligible for Alaska's Medicaid Breast and Cervical Treatment Program remains eligible for the program "during the period that the woman is *receiving treatment* for breast, cervical, or directly related cancer" (emphasis added). Based on the CMS policy statements quoted in the *Hauser* decision, the Claimant's tests in this case constitute "routine monitoring for precancerous conditions" rather than required/necessary treatment for existing cancer. Accordingly, the three tests ordered in this case (i.e. the CBC, CMP, and CA 125) do not constitute "treatment" within the terms of the BCCPTA.

In this case the Hearing Authority originally concluded that the Claimant's cancer treatment had not ended as of May 12, 2010, the date the Division gave notice of its termination of the Claimant's benefits. However, that decision was incorrect, as explained above. Because the Claimant was no longer undergoing treatment as of May 12, 2010, the Division was correct to terminate the Claimant's participation in the Medicaid Breast and Cervical Treatment Program after May 31, 2010. Accordingly, the Division's motion to reconsider this Office's decision dated October 25, 2010 must be granted, and the Decision dated October 25, 2010 is hereby vacated.

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, the Claimant must send a written request directly to:

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

An appeal 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 25th day of January, 2011.

Signed
Jay Durych
Hearing Authority

[This document has been modified to conform to the technical standards for publication.]

Office of Hearings and Appeals
3601 C Street, Suite 1322
P. O. Box 240249
Anchorage, AK 99524-0249
Phone: (907) 334-2239
Fax: (907) 334-2285

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

In the Matter of	)	
	)	
[redacted]	)	OHA Case No. 10-FH-172
	)	
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 April 30, 2010, Claimant submitted a recertification application for services. (Ex. 2 – 2.5) On May 12, 2010, the Division of Public Assistance sent notice stating her benefits would end on May 31, 2010 because she was "no longer in treatment for breast or cervical cancer." (Ex. 4)

Claimant submitted a Fair Hearing Request on May 21, 2010 (Ex. 5.1). This office has jurisdiction to resolve this dispute pursuant to 7 AAC 49.010.

A hearing was held on July 21, 2010 and was continued until August 25, 2010. Claimant attended the hearing in person, 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.

ISSUE

The Division terminated Claimant's benefits under the Breast and Cervical Cancer Treatment category on May 31, 2010 because it believed treatment had ended.

Claimant argues treatment has not ended. She would like to continue in oncology rehabilitation which involves weight training, light stretching, nutrition and diet supplements, and mind and body visualization. She also would like to see a gynecologist and obtain a pap smear 4 times a year, 2 cat scans a year, blood work 4 times a year, and a colonoscopy every 2 years.

The issue is:

> Was the Division correct to send Claimant notice on May 12, 2010 terminating her Medicaid benefits under the Breast and Cervical Cancer Treatment category on May 31, 2010 because the Claimant's cancer treatments had ended?

FINDINGS OF FACT

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

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

2. Claimant was diagnosed with uterine and cervical cancer in July of 2009. (Ex. 11.3) Claimant had a complete hysterectomy on August 6, 2009. (Ex. 11)

3. On August 6, 2009, Claimant's treating physician, [redacted] M.D., prescribed 6 cycles of chemotherapy. (Ex. 11.1)

4. On August 28, 2009, Claimant began chemotherapy treatment with [redacted] M.D. (Ex. 11.2)

5. On May 4, 2010, Dr. [redacted] wrote the following in the assessment/plan section of his report:

> Endometrial cancer. She had surgical debulking and is status post 6 cycles of carboplatin and Taxol. She finished chemotherapy in 12/2009. She continues to have no evidence of recurrence. She is recovering from chemotherapy quite well. Her performance status continues to improve. At this point we will have her follow-up in 3 months with a repeat CBC, CMP, and CA 125. I asked her to call if she has any new symptoms or concerns.

(Ex. 11.24)

6. On May 12, 2010, the Division sent Claimant notice stating her Medicaid coverage for the Breast and Cervical Program would end on May 31, 2010. (Ex. 4) The Division stated the reason for this termination was that Claimant was "no longer in treatment for breast and cervical cancer." (Ex. 4)

7. Claimant testified she is currently receiving oncology rehabilitation. She receives weight training, light stretching, nutrition and diet supplementation, and mind/body

visualization. This program is a maintenance program. Claimant provided no medical documentation regarding this program.

PRINCIPLES OF LAW

I. Applicable Burden of Proof and Standard of Proof.

"Ordinarily the party seeking a change in the status quo has the burden of proof." *State, Alcohol Beverage Control Board v. Decker*, 700 P.2d 483, 485 (Alaska 1985). The standard of proof in an administrative proceeding is a "preponderance of the evidence," unless otherwise stated. *Amerada Hess Pipeline Corp. v. Alaska Public Utilities Com'n*, 711 P.2d 1170, 1183 (Alaska 1986)

"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." *Robinson v. Municipality of Anchorage,* 69 P.3d 489, 495 (Alaska 2003)

II. Medicaid Program Background.

Because Medicaid is a federal program, 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.

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. Medicaid Breast and Cervical Cancer 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).

Alaska regulation, 7 AAC 100.710, implements the BCCPTA in Alaska and 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)

(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).

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

Hauser v. Idaho Department of Health and Welfare, 2004 WL 1854250 (Idaho Dist. Ct. 2004). 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

The issue in this case is whether the Division correct to send Claimant notice on May 12, 2010 terminating her Medicaid benefits under the Breast and Cervical Cancer Treatment category on May 31, 2010 because her cancer treatments had ended.

Because this case involves a continuation of benefits, with a recertification application, the Division is the party seeking to change the status quo. Therefore it has the burden of proof by a preponderance of the evidence.

This case is controlled by State regulation 7 AAC 100.710(b) which states that a woman remains eligible during the period she is receiving treatment and "[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." 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.

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). 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, on May 4, 2010 Claimant's treating physician in the "assessment/plan" section of his report ordered follow-up in three months with a "repeat CBC, CMP, and CA 125." Thus it is clear the Claimant's physician is setting forth a treatment plan that extends to three months in the future, through August 2010. This is very similar to the treating physician's treatment plan in *Hauser*. Furthermore, Claimant's physician states Claimant "is recovering" and "continues to improve." This is language that indicates continued treatment with some recovery remaining.

In summary, the Division had the burden of proving, pursuant to 7 AAC 100.710(b), that the treatment plan established by Claimant's treating health care professional had ended. Claimant did not meet its burden. The Division was therefore not correct to terminate the Claimant's participation in the Medicaid Breast and Cervical Cancer Treatment Program on May 31, 2010.

CONCLUSIONS OF LAW

1. The Division failed to meet its burden of proof by a preponderance of the evidence that Claimant's breast cancer treatment ended on or before May 12, 2010.

2. The evidence shows that on May 4, 2010 Claimant's physician recommended a treatment plan that included a follow up in 3 months and additional testing. Thus, pursuant to 7 AAC 100.710(b) the Claimant's Medicaid eligibility under the Breast and Cervical Cancer Treatment category did not end on May 12, 2010.

3. The Division was therefore not correct to terminate the Claimant's participation in the Medicaid Breast and Cervical Cancer Treatment category after May 31, 2010.

DECISION

The Division was not correct to end the Claimant's participation in the Medicaid Breast and Cervical Cancer Treatment category on May 31, 2010.

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 25th day of October, 2010.

[redacted]

Patricia Huna
Hearing Authority

CERTIFICATE OF SERVICE

I certify that on this 25th day of October 2010, 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 [redacted]
J. Albert Levitre, Jr.
Law Office Assistant I