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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. 11-FH-2218
	)	
Claimant.	)	DSDS Case No. [redacted]
	)	
	)	

FAIR HEARING DECISION

STATEMENT OF THE CASE

[redacted] (Claimant) was, prior to June 25, 2011, enrolled in the Medicaid Home and Community-Based Waiver Services Program (hereafter "Waiver Services Program") (Ex. D-1). On May 25, 2011 the State of Alaska Division of Senior and Disabilities Services (DSDS or Division) mailed a letter to the Claimant [1] stating that she would be disenrolled from the Waiver Services Program for the Mentally Retarded / Developmentally Disabled ("MRDD Waiver Program"), based on the assertion that the Claimant's care coordinator had not timely taken action and/or submitted documentation as required by 7 AAC 130.210(a) and 7 AAC 130.230 (Ex. D-1). The Claimant requested a fair hearing to contest her disenrollment from the MRDD Waiver Services Program on May 27, 2011 (Ex. C).

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

The Claimant's hearing began as scheduled on August 2, 2011 before Hearing Examiner Jay Durych. The Claimant's parents, [redacted] and [redacted], participated in the hearing by telephone, represented the Claimant, and testified on her behalf. The head of the Claimant's care coordination agency, [redacted], [2] also participated by telephone, assisted in representing the

[1] The Claimant is a minor, currently 14 years of age (Ex. D-1). Accordingly, notices sent by DSDS regarding the Claimant's waiver services were actually sent to the Claimant's parents. In this decision, actions attributed to the Claimant include actions by the Claimant's parents on her behalf.

[2] Mr. [redacted] is not the particular care coordinator whom the Division asserts failed to timely file documentation on behalf of the Claimant; however, he does work at the same care coordination agency.

Claimant, and testified on the Claimant's behalf. [redacted], a Medical Assistance Administrator III for DSDS, attended the hearing in person and represented DSDS. [redacted], a Health Program Manager II for DSDS, attended the hearing in person as a witness for DSDS. The witnesses' testimonies were received and all exhibits submitted were admitted into evidence. At the end of the hearing the record was closed and the case became ripe for decision.

ISSUE

Was the Division correct when, on May 25, 2011, it notified the Claimant that she would be disenrolled from the Medicaid Home and Community-Based Waiver Services Program, effective 30 days from the date of the notice, based on the assertion that the Claimant's care coordinator did not timely take action or submit documentation as required by 7 AAC 130.210(a) and 7 AAC 130.230?

SUMMARY OF DECISION

The Division carried its burden and proved, by a preponderance of the evidence, that the Claimant failed to submit her proposed Plan of Care to DSDS as required by 7 AAC 130.230(h). The Division was therefore justified in beginning proceedings to disenroll the Claimant from the MRDD Waiver Services Program.

The Division also carried its burden and proved, by a preponderance of the evidence, that it complied with the notice requirements of MRDD Waiver Services regulation 7 AAC 130.210(a) prior to disenrolling the Claimant from the MRDD Waiver Services Program.

The Division was therefore correct when, on May 25, 2011, it notified the Claimant that she would be disenrolled from the Medicaid Home and Community-Based Waiver Services Program, effective 30 days from the date of the notice, because Claimant's care coordinator did not timely submit documentation (i.e. a Plan of Care) as required by 7 AAC 130.210(a) and 7 AAC 130.230.

FINDINGS OF FACT

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

1. The Claimant has received Medicaid benefits under the Home and Community-Based Waiver Services Program for the Mentally Retarded / Developmentally Disabled ("MRDD Waiver Program") since approximately December 2007 (Ex. K-2).

2. On or about April 4, 2010 [redacted] was replaced by [redacted] as the Claimant's care coordinator (Exs. R-1, R-2). However, both [redacted] and Ms. [redacted] work for the same care coordination agency ([redacted] testimony, [redacted] testimony). DSDS records indicate that it was made aware of the transfer of care coordination responsibilities on July 2, 2010 (Ex. K-1).

3. The Claimant's renewed Level of Care (LOC) determination was issued by DSDS on July 20, 2010 ([redacted] testimony). Pursuant to 7 AAC 130.230(h), a benefit recipient has thirty (30) days from the date of the Level of Care (LOC) determination to submit a proposed new Plan of Care (POC). *Id.* DSDS did not receive the Claimant's proposed new Plan of Care by August 20, 2010 (i.e. by the end of the 30 day period specified by 7 AAC 130.230(h)). *Id.*

4. In March 2011 DSDS realized that it had not yet received the Claimant's proposed new Plan of Care which had been due by August 20, 2010 ([redacted] testimony). Accordingly, on March 7, 2011 DSDS sent an e-mail to the Claimant's care coordinator reminding her that the Claimant's annual Plan of Care was overdue (Ex. N-1). The e-mail, titled "This is a request for the Annual Plan of Care," stated in relevant part as follows:

> [DSDS] is processing the renewal plan of care for [the Claimant's Home and Community-Based Waiver Services for the Mentally Retarded / Developmentally Disabled]. We are unable to proceed due to the following missing or incomplete documents or information: Plan of Care.
>
> [The notice then summarized MRDD Waiver Services regulation 7 AAC 130.230, set forth in the Principles of Law section of this decision, below].
>
> If [DSDS] does not receive the needed information, by March 10, 2011, [DSDS] will send you a notice . . . requesting the information. A courtesy copy of that notice will also be sent to the participant or their legal representative.

5. DSDS did not receive the Claimant's annual Plan of Care by March 10, 2011 ([redacted]). Accordingly, on March 11, 2011 DSDS e-mailed a notice, titled "Notice of Insufficient Documentation," to the Claimant's care coordinator (Exs. E-1, O-1). This e-mailed notice was sent via You-Send-It, a secure e-mail service which provides a record of the e-mail's sending and receipt (Ex. O-2, [redacted] testimony). The notice was cross-copied to the Claimant's father via regular mail (Ex. O-1, [redacted] testimony). The notice stated in relevant part as follows (Exs. E-1, O-1):

> [DSDS] is processing the renewal plan of care for [the Claimant's Home and Community-Based Waiver Services for the Mentally Retarded / Developmentally Disabled]. We are unable to proceed due to the following missing or incomplete documents or information: Plan of Care.
>
> [The notice then summarized MRDD Waiver Services regulation 7 AAC 130.230, set forth in the Principles of Law section of this decision, below].
>
> [DSDS] sent you an e-mail on March 7, 2011 to request the needed information. If [DSDS] does not receive the needed information, within 10 days from the date of this letter, [DSDS] will not be able to process the request for services. If we do not hear from you, the participant and their legal representative will receive another notice requesting that they submit the needed information directly to [DSDS], and reminding them that they may also choose a new care coordinator....

6. DSDS did not receive any response to its March 11, 2011 notice ([redacted] testimony). Accordingly, on March 25, 2011 DSDS sent out a second notice titled "Notice of Insufficient Documentation" (Exs. F-1, F-2, P-1, P-2). A "hard copy" of the notice was sent to the Claimant's father via certified mail, return receipt requested (Exs. F-1, P-1, P-5). This copy of the notice was signed for as received by the Claimant's father on April 6, 2011 (Ex. P-4). The notice was cross-copied to the Claimant's care coordinator via the You-Send-It secure e-mail service (Ex. P-3). The Division's notice stated in relevant part as follows (Exs. F-1, P-1):

> [DSDS] is processing your renewal plan of care for [the Claimant's Home and Community-Based Waiver Services for the Mentally Retarded / Developmentally Disabled]. We are unable to proceed due to the following missing or incomplete documents or information: Plan of Care.
>
> [The notice then summarized MRDD Waiver Services regulation 7 AAC 130.230, set forth in the Principles of Law section of this decision, below].
>
> [DSDS] sent your care coordinator an e-mail on March 7, 2011 to request the needed information. [DSDS] then sent a notice to your care coordinator on March 11, 2011 to again attempt to get the information needed to process your request for services. If [DSDS] does not receive the needed information, within 30 days from the date you receive this letter, [DSDS] will not be able to process your request for services. Regulation 7 AAC 130.210 requires that [DSDS] tell you that you may also submit the needed information directly to [DSDS] rather than through your care coordinator. You may also choose a new care coordinator from the enclosed list if you choose to do so. If we do not receive the needed information or hear from you, you will receive another notice informing you that your enrollment in the program is being discontinued . . . .

7. DSDS did not receive any response to its March 25, 2011 notice ([redacted] testimony). Accordingly, two months later, on May 25, 2011 DSDS sent out a notice titled "Disenrollment from Home and Community-Based Waiver Service" (Exs. D-1, D-2). A "hard copy" of the notice was sent to the Claimant's father via certified mail, return receipt requested (Exs. D-1, I-2). This copy of the notice was signed for as received by the Claimant's mother on May 28, 2011 (Ex. I-1). The notice was cross-copied to the Claimant's care coordinator via the You-Send-It secure e-mail service (Ex. D-2, [redacted] testimony). The Division's notice stated in relevant part:

> [DSDS] sent your care coordinator an e-mail on March 7, 2011 asking for information required to process your request for services. [DSDS] then sent a notice to you and your care coordinator on March 11, 2011 to again attempt to get the required information. A third notice was sent March 25, 2011 requesting required information and stating that failure to provide this information would result in disenrollment from Home and Community-Based Waiver Services.

> This letter is intended to provide you with notice of [DSDS]' action to disenroll you from the Home and Community-Based Waiver effective 30 days from receipt of this letter for the following reasons listed in 7 AAC 130.210(a):
>
> [The notice then quoted MRDD Waiver Services regulation 7 AAC 130.210(a)(5), set forth in the Principles of Law section of this decision, below].
>
> [DSDS] issued [the Claimant's Level of Care determination on] July 20, 2010. [Per regulation 7 AAC 130.230, the care coordinator is required to submit a plan of care within 30 days after completion of a new assessment / level-of care determination]. To date, DSDS has not received this plan of care.

8. On May 25, 2011 Mr. [redacted] sent an e-mail to DSDS which stated in relevant part as follows (Exs. J-1, J-2):

> This POC [Plan of Care] was sent on 10/03/2010. Also this is the first e-mail being received for this notice. This family was seen every month since this was submitted and they've not informed us of receiving any of [the] notices you sent out.
>
> Your letter stated that you've contacted our office through e-mail 3 times to inform us of missing information [to submit a Plan of Care]. Could you please provide us with copies of [these e-mails]. We had recently submitted an ICAP [Inventory for Client and Agency Planning] request for [Claimant] for next LOC [Level of Care] year and never heard from [DSDS] that they've not received this [Plan of Care].
>
> * * * * * * * * * * * *
>
> Also, I've notified [DSDS] on several occasions that they [DSDS] have our e-mail wrong. I've personally contacted . . . [DSDS staff] that we were not getting notifications and asked that they update the correct e-mails.

9. On May 25, 2011 Mr. [redacted] sent a document to DSDS via the You-Send-It secure e-mail service (Ex. J-3). The e-mail identifies the attached document as "2010 POC Renewal Packet initially sent 10/03/2010 to SDS" (Ex. J-3). However, no copy of the actual document (i.e. the Plan of Care itself) was provided by the Claimant's representatives at hearing.

10. DSDS has no record of receiving the Plan of Care which Mr. [redacted] indicated had been sent to DSDS on 10/03/2010 (Ex. K-1, [redacted] testimony). DSDS also has no record of any communication with the Claimant's family or care coordination agency, regarding the Claimant's case, from July 2, 2010 to March 7, 2011 (Ex. K-1, [redacted] testimony).

11. On July 28, 2011 Mr. [redacted] sent an e-mail to DSDS (Exs. G-1, G-2) which stated in relevant part as follows:

Am hoping with [the attached prior e-mails between his agency and DSDS] you'll see my attempts to notify [DSDS] that we were not getting some notifications because our e-mail was wrong . . . . I know the family was sent [a notice by] mail but they stated they were confused . . . .

12. At the hearing of August 2, 2011 Mr. [redacted] credibly testified in relevant part:

a. He was originally the Claimant's care coordinator. However, care coordination duties were transferred to [redacted] on April 4, 2010. The transfer was made because it was felt that it would be best to have a female care coordinator, since the Claimant is female and is entering adolescence.

b. His agency did receive the Level of Care certification/determination notice from DSDS in July 2010. However, it sometimes takes a long time to gather the information necessary to prepare a Plan of Care.

c. His agency sent the Claimant's Plan of Care to DSDS via the You-Send-It secure e-mail service on October 3, 2010. However, he has no written confirmation of this. He tried to obtain a receipt for the e-mail in question from the You-Send-It service. However, by the time he tried to find the receipt it was May 2011, (over seven months after the e-mail was sent), and the You-Send-It service does not maintain delivery receipts for that long.

d. The reason his agency did not follow-up with DSDS regarding that filing was because it sometimes takes DSDS a long time to review a Plan of Care. He and his agency just assumed that DSDS was working on it and that they would hear back from DSDS when its review was completed.

e. DSDS was not using his correct e-mail address during the period in question. The only e-mail communication he received from DSDS during the period in question was the May 25, 2011 disenrollment notice. He did not receive any of the prior reminder/warning notices. If he had he would have responded immediately.

f. The Claimant's parents are generally very cooperative and very responsive to any requests by his care coordination agency. The Claimant's parents did receive the notices regarding the need to submit the Claimant's Plan of Care. However, they were confused about what DSDS was asking for in the spring of 2011. They thought the notices from DSDS were about the Claimant's 2011 Inventory for Client and Agency Planning (ICAP), not the Claimant's 2010 Plan of Care.

g. He had numerous telephone contacts with various DSDS personnel, regarding numerous other DSDS cases, throughout the time period at issue in this case. It is strange that DSDS never mentioned that it was still awaiting receipt of a Plan of Care in this case during the discussions regarding all the other cases.

13. At the hearing of August 2, 2011 [redacted] of DSDS credibly testified in relevant part as follows:

a. She is a Health Program Manager II for DSDS. She is the supervisor of the reviewers for the Individuals with Developmental Disabilities (IDD) Waiver Services Program for the Anchorage area. She is personally familiar with this case. She issued the disenrollment letter dated May 25, 2011.

b. It is typical for DSDS to send and receive information by mail, by fax, by e-mail, and by the You-Send-It secure e-mail service. However, all notices sent having legal significance are sent via certified mail, return receipt requested.

c. DSDS has approximately 1,800 participants in the program at issue, but only three employees in the unit processing the Plans of Care. Accordingly, DSDS does not have the resources to place reminder or follow-up telephone calls to recipients or their care coordinators.

d. Mr. [redacted] contacted DSDS's Certification Unit on October 25, 2010 and updated/corrected his agency's e-mail addresses, as indicated in Ex. H-2. However, DSDS did not actually correct the e-mail addresses in its DS3 database until April 21, 2011, as indicated in Ex. H-1.

e. However, DSDS used the correct e-mail addresses for Mr. [redacted]'s care coordination agency when it originally notified his agency that the Claimant had met the required level of care back on July 20, 2010. The thirty day timeline for submitting the Claimant's proposed new Plan of Care ran from the date that DSDS notified the care coordination agency that the required level of care had been met.

f. The ICAP was not issued by DSDS in this case until April 28, 2011. Accordingly, there should not have been any confusion between the March 2011 notices requesting submission of the Plan of Care, and the April 28, 2011 ICAP-related correspondence.

g. Had the Claimant submitted a proposed new Plan of Care to DSDS within thirty days of receipt of the March 25, 2011 "Notice of Insufficient Documentation," DSDS would have accepted the Plan of Care as timely and would not have continued on with its disenrollment proceedings.

PRINCIPLES OF LAW

I. Burden of Proof and Standard of Proof.

The party seeking a change in the status quo or existing state of affairs normally bears the burden of proof. [3] This case involves the Division's disenrollment of the Claimant from a Medicaid

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

Waiver Services Program. As such, the case involves the Division's de-facto termination of the Claimant's previously existing Medicaid Waiver Services benefits. Because the Division is seeking to change the status quo by terminating the Claimant's Medicaid Waiver Services benefits, the Division bears the burden of proof in this case.

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. [4] 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. [5]

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). Medicaid is, in the words of Judge Friendly, "a statute of unparalleled complexity." *DeJesus v. Perales,* 770 F.2d 316, 321 (2nd Cir. 1985).

On the federal level, the Secretary of the U.S. Department of Health and Human Services ("HHS") administers the Medicaid Program through the Centers for Medicare & Medicaid Services ("CMMS"), formerly known as the Health Care Financing Administration ("HCFA"). 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.

In Alaska, the Department of Health and Social Services administers the Medicaid program on the state level. 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. The Medicaid Home and Community-Based Waiver Services Program.

Medicaid Home and Community-Based Waiver Services Programs (also known as "Waiver" programs) allow people, who would otherwise need an institutional level of care, to continue to live in their home or community and receive the care they need without being institutionalized. *See* DSDS website at http://www.hss.state.ak.us/dsds/grantservices/hcbwaivers.htm (date

[4] 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).

[5] *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").

accessed August 21, 2011). Waiver programs are approved by the federal government and allow Alaska to provide expanded services to people who meet the eligibility criteria for the specific waiver program. *Id.*

Alaska currently has four different Waiver programs. *See* DSDS website, referenced above. The four programs are (1) Adults with Physical Disabilities ("APD"), Children with Complex Medical Conditions ("CCMC"), Mentally Retarded / Developmentally Disabled ("MRDD)", and Older Alaskans ("OA") *Id.*

IV. The Waiver Program For The Mentally Retarded / Developmentally Disabled.

This case involves the Waiver program for the Mentally Retarded / Developmentally Disabled ("MRDD)." The regulations for administration of the MRDD program are located at 7 AAC 130.200 – 7 AAC 130.319. The purpose of 7 AAC 130.200 - 7 AAC 319, as stated in 7 AAC 130.200, is "to offer a choice between home and community-based waiver services and institutional care to aged, blind, physically or developmentally disabled, or mentally retarded persons who meet the eligibility criteria in 7 AAC 130.205."

7 AAC 130.210, titled "Recipient Disenrollment," provides in relevant part as follows:

> (a) The department will disenroll a recipient for one or more of the following reasons:
>
> * * * * * * * * * * * *
>
> (4) the recipient fails to take an action or submit documentation as required in 7 AAC 130.230;
>
> (5) the recipient's care coordinator, on the behalf of the recipient, fails to take an action or submit documentation as required in 7 AAC 130.230, if the department has provided the recipient with written notice
>
> (A) identifying the action the care coordinator did not take or the documentation the care coordinator did not provide;
>
> (B) indicating that the recipient has 30 days to take the action or submit the documentation required;
>
> (C) informing the recipient that the recipient may choose a new care coordinator; and
>
> (D) indicating whether the department is not willing to assume the duties of care coordination under 7 AAC 130.230(i) . . . .

7 AAC 130.230, titled "Screening, Assessment, Plan of Care, and Level-of-Care Determination," provides in relevant part as follows:

> (c) After the level of care is established, the care coordinator shall
>
> (1) prepare, in writing, a plan of care addressing (A) the comprehensive needs of the recipient; (B) the availability of enrolled providers; (C) the types of services that have been agreed to by specific enrolled providers; (D) family and community supports; and (E) the number of units, frequency, projected duration, and projected cost of each home and community-based waiver service;
>
> (2) include in the plan of care an analysis of whether the type, amount, duration, and scope of services in the plan of care are consistent with the findings of the assessment in (b) of this section and with any other treatment plan for the recipient;
>
> (3) make a recommendation whether the services in the plan of care meet the identified needs of the recipient;
>
> (4) support the plan of care with appropriate and contemporaneous documentation that (A) relates to each medical condition that places the recipient into a recipient category listed in 7 AAC 130.205(d)(1); and (B) describes, supports, or justifies the recipient's request and need for home and community-based waiver services; and
>
> (5) present the plan of care to the department for consideration and approval, and for consideration and approval of the home and community-based waiver services requested in the plan of care.
>
> * * * * * * * * * * *
>
> (g) A recipient's need for home and community-based waiver services must be reviewed annually using the same criteria used to determine initial eligibility under 7 AAC 130.205. A new assessment must be prepared in accordance with (b) of this section, and the recipient's plan of care must be changed accordingly, unless the department determines that an earlier review is necessary due to changing and significant events in the health and welfare of the recipient. The care coordinator shall submit in writing, for the department's consideration and approval, any change to a recipient's plan of care, shall document the need for changes to the plan of care, and shall relate those changes to findings in the current assessment. If a comprehensive planning team is required under (d) of this section, the team must participate in preparing, in accordance with that subsection, any subsequent changes to the plan of care . . . .

> (h) The plan of care required in (c) of this section must be completed no more than 60 days after completion of an initial assessment required in (b) of this section, or no more than 30 days after the completion of a new assessment required in (g) of this section, unless the care coordinator submits written documentation of unusual circumstances that would prevent timely completion of the plan of care.

7 AAC 130.240, titled "Care Coordination Services," provides in relevant part as follows:

> (c) . . . . Ongoing care coordination services include (1) routine monitoring and support; (2) review and revision of a plan of care under 7 AAC 130.230(g); (3) case terminations; (4) two contacts each month with the recipient, one of which must be face-to-face . . . . (5) evaluation of the need for specific home and community-based waiver services; (6) coordination of multiple services and providers; and (7) monitoring of the quality of care.

ANALYSIS

Introduction: Definition of Issues; Burden of Proof.

There are two issues to be decided in this case. Those issues are:

> 1. Did the Claimant timely submit a proposed new Plan of Care, within thirty days of receipt of the Claimant's new / annual assessment or Level of Care determination, as required by 7 AAC 130.230(h)?
>
> 2. If the answer to (1), above is "yes," did the Division provide the Claimant and her care coordination agency with the notice required by 7 AAC 130.210(a)(5) prior to disenrolling the Claimant from the MRDD Waiver Services Program?

Because the Division is the party seeking to change the status quo by terminating the Claimant's MRDD Waiver Services, the Division bears the burden of proof in this case. *See* Principles of Law at page 7, above.

I. Did the Claimant Timely Submit a Proposed New Plan of Care?

The Claimant was required, pursuant to 7 AAC 130.230(h), to submit a proposed new Plan of Care to DSDS within thirty days of receipt of the Claimant's new / annual assessment or Level of Care determination from DSDS. *See* Principles of Law at page 10, above.

The Claimant's renewed Level of Care (LOC) determination was issued by DSDS on July 20, 2010 ([redacted] testimony). Mr. [redacted] confirmed at hearing that his agency received the Level of Care certification / determination notice from DSDS in July 2010. Ms. [redacted] testified that DSDS did not receive the Claimant's proposed new Plan of Care by the end of the 30 day period specified by 7 AAC 130.230(h)). Mr. [redacted] did not dispute this. Accordingly, the parties agree that the Claimant failed to submit her proposed new Plan of Care to DSDS within thirty days of

receipt of the Claimant's new / annual assessment or Level of Care determination from DSDS, as required by 7 AAC 130.230(h).

Ms. [redacted] testified that, had the Claimant submitted a proposed new Plan of Care to DSDS within thirty days of receipt of the March 25, 2011 "Notice of Insufficient Documentation," DSDS would still have accepted the Plan of Care as timely, and would not have continued with its disenrollment proceedings, even though the Plan of Care would technically have been about eight months late.

Mr. [redacted] testified that his agency sent the Claimant's Plan of Care to DSDS via the You-Send-It secure e-mail service on October 3, 2010. However, he was unable to provide written confirmation of this. Ms. [redacted] testified that DSDS has no record of receiving the Plan of Care which Mr. [redacted] indicated had been sent to DSDS on October 3, 2010. In summary, the evidence indicates that the Claimant's care coordination agency *may* have *sent* a Plan of Care to DSDS by e-mail. However, there is no evidence whatsoever that the Claimant's Plan of Care was ever actually *received* by DSDS.

MRDD Waiver Services regulation 7 AAC 130.230(g) requires the care coordinator to "submit" the Plan of Care to DSDS. Webster's online dictionary defines "submit" in relevant part as "to present or propose to another for review, consideration, or decision . . . to deliver formally." *See* http://www.merriam-webster.com/dictionary/submit (date accessed September 22, 2011). MacMillan's online dictionary similarly defines "submit" in relevant part as "to formally give something to someone so that they can make a decision about it." See http://www.macmillandictionary.com/dictionary/british/submit (date accessed September 22, 2011). It is thus apparent, based on the generally accepted definition of the term "submit," that the Plan of Care was not "submitted" to DSDS until it was actually *received* by DSDS.

Accordingly, the Division has carried its burden and proven, by a preponderance of the evidence, that the Claimant failed to submit her proposed new Plan of Care to DSDS as required by 7 AAC 130.230(h). The Division was therefore justified in beginning proceedings to disenroll the Claimant from the MRDD Waiver Services Program. The remaining issue is whether the Division properly followed the *notice procedures* required as a prerequisite to disenrollment.

II. Did the Division Follow the Required Pre-Disenrollment Notification Procedures?

MRDD Waiver Services regulation 7 AAC 130.210(a) states the contents of the notice that must be provided to a benefit recipient prior to disenrollment. Pursuant to 7 AAC 130.210(a), DSDS must provide the recipient, (not the care coordinator) with a written notice which (1) identifies the action the care coordinator did not take or the documentation the care coordinator did not provide; (2) indicates that the recipient has 30 days to take the action or submit the documentation required; (3) informs the recipient that the recipient may choose a new care coordinator; and (4) if the department is willing to assume the duties of care coordination, indicating same. *See* Principles of Law at page 8, above.

DSDS' notice dated March 25, 2011, titled "Notice of Insufficient Documentation" (Exs. F-1, F-2, P-1, P-2), satisfied the requirements of 7 AAC 130.210(a). The notice:

1. Specifically identified the action the care coordinator did not take or the documentation the care coordinator did not provide as "Plan of Care;"

2. Specifically indicated that the Claimant had 30 days to submit the documentation required (i.e. the Plan of Care); and

3. Specifically informed the Claimant that the Claimant could choose a new care coordinator. [6]

The "hard copy" of this notice was sent to the Claimant's father via certified mail, return receipt requested (Exs. F-1, P-1, P-5), and was signed for as received by the Claimant's father on April 6, 2011 (Ex. P-4).

Accordingly, the Division carried its burden and proved, by a preponderance of the evidence, that it complied with the notice requirements of MRDD Waiver Services regulation 7 AAC 130.210(a) prior to disenrolling the Claimant from the MRDD Waiver Services Program. The Division was therefore correct when, on May 25, 2011, it notified the Claimant that she would be disenrolled from the Medicaid Home and Community-Based Waiver Services Program, effective 30 days from the date of the notice, because the Claimant's care coordinator did not timely take action or submit documentation (i.e. a Plan of Care) as required by 7 AAC 130.210(a) and 7 AAC 130.230.

CONCLUSIONS OF LAW

1. The Division carried its burden and proved, by a preponderance of the evidence, that the Claimant failed to submit her proposed new Plan of Care to DSDS as required by 7 AAC 130.230(h). The Division was therefore justified in beginning proceedings to disenroll the Claimant from the MRDD Waiver Services Program on March 25, 2011.

2. The Division carried its burden and proved, by a preponderance of the evidence, that it complied with the notice requirements of MRDD Waiver Services regulation 7 AAC 130.210(a) prior to disenrolling the Claimant from the MRDD Waiver Services Program on May 25, 2011.

DECISION

The Division was correct when, on May 25, 2011, it notified the Claimant that she would be disenrolled from the Medicaid Home and Community-Based Waiver Services Program, effective 30 days from the date of the notice, because the Claimant's care coordinator did not timely submit documentation (i.e. a Plan of Care) as required by 7 AAC 130.210(a) and 7 AAC 130.230.

[6] Because DSDS was not willing to assume the duties of care coordination itself, it was not required to make that offer in its notice.

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. 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. To appeal, send a written request directly to:

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

Dated this 22nd day of September, 2011.

(signed)
_____
Jay Durych
Hearing Authority

CERTIFICATE OF SERVICE

I certify that on September 22, 2011 true and correct copies of this document were sent to the following persons via the United States Postal Service, Certified Mail, Return Receipt Requested:

Claimant

I certify that on September 22, 2011 true and correct copies of this document were sent to the following persons by secure / encrypted e-mail:

[redacted], DHCS / DSDS Hearing Representative
[redacted], Director, DSDS
[redacted], Policy & Program Development
[redacted], Staff Development & Training
[redacted], Eligibility Technician I

(signed)
By:_____
J. Albert Levitre, Jr.
Law Office Assistant I