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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-2352
	)	
Claimant.	)	Division Case No. [redacted]

ERRATA

On January 17, 2012, a Decision in this case was issued. Please take note of the following:

1. On page 1, a typographical error exists in the reference to the jurisdiction of the Office of Hearings and Appeals. The correct reference is: **42 C.F.R. § 431.200-431.250**, not 441.200-441.250.

Dated January 20, 2012.

/signed/
Claire Steffens
Hearing Authority

CERTIFICATE OF SERVICE

I certify that on February 10, 2012 true and correct copies of the foregoing were sent to:

Claimant, via her legal representative, Disability Law Center, c/o Mr. Mark Regan by certified mail, return receipt requested
and via secure, encrypted e-mail, to Claimant and others as follows:

Division of Senior and Disabilities Services, via Kimberly Allen, Asst. Attorney General
[redacted], Hearing Representative
[redacted], Director, DSDS
[redacted], Chief, Policy & Program Dev.
[redacted] Eligibility Technician
[redacted], Staff Development & Training

/signed/
J. Albert Levitre, Jr.
Law Office Assistant I

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In the Matter of	)	
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[redacted],	)	OHA Case No. 11-FH-2352
	)	
Claimant.	)	Division Case No. [redacted]

FAIR HEARING DECISION

STATEMENT OF THE CASE

Ms. [redacted] (Claimant) was receiving Medicaid benefits under the Home and Community-Based Waiver (HCBW) Mentally Retarded and Developmentally Disabled (MRDD) program. (Ex. A, pp. 1-2) Claimant submitted a proposed amendment to her existing plan of care on February 28, 2011. (Ex. A, p. 2) Included in Claimant's proposed amendment was a request that Medicaid pay her group-home an acuity rate amount, supplementing its daily rate, for 72 days.[1] (Ex. F) The acuity rate payment was requested so the group-home would provide one-on-one staff dedicated to Claimant 24 hours a day, seven days a week. (Ex. F, p.1; 7 AAC 145.520(m)) On August 15, 2011, the Division of Senior and Disabilities Services (SDS) notified Claimant it had denied the requested "72 units (72 days)" of "Acuity Add-On" Medicaid payment. (Ex. D)

On September 7, 2011, Claimant requested a Fair Hearing.[2] (Ex. C, p. 2) This office has jurisdiction pursuant to 42 C.F.R. §441.200-441.250 and 7 AAC 49.010-.020.[3]

A Fair Hearing was scheduled for October 5, 2011. Claimant supplied the Division with additional information and the parties agreed to re-schedule the hearing for October 17, 2011. On October 17,

[1] Claimant's proposed amended plan of care also requested 72 units (72 days) of Residential Habilitation Group Home service and 640 units (16 hours per week, for 10 weeks) of Day Habilitation service, which were approved as requested. (Ex. D) This case concerns only the denied Acuity Add-On portion of Claimant's proposed amended plan of care.

[2] Claimant's request for Fair Hearing was made by letter dated September 7, 2011 and documented as received on September 9, 2011. (Ex. C, p. 1)

[3] Alaska regulation 7 AAC 49.020(4) provides a Fair Hearing to individuals whose "request for a covered Medicaid service has been denied."

2011, the hearing began as scheduled. Claimant was represented by the Disability Law Center of Alaska which participated through Mr. Mark Regan, Legal Director. Claimant was assisted by her mother and father, Mr. and Mrs. [redacted], who participated in person and testified on behalf of Claimant. The Alaska Division of Senior and Disabilities Services (Division) was represented by Ms. Kimberly Allen, Assistant Attorney General, Department of Law, who participated in person. Ms. [redacted], Health Program Manager for Senior and Disabilities Services (Division's Reviewer) participated in person and testified on behalf of the Division. The hearing continued on October 26, 2011 and was attended by the same persons who attended on October 17, 2011.

The evidentiary record was closed at the end of the hearing on October 26, 2011. Closing briefs were received from both parties and the hearing record was closed on December 5, 2011.

PROCEDURAL MATTERS

1. Motion in Limine

On October 17, 2011, the Office of Hearing and Appeals received from Claimant a document titled "Additional Exhibit and Prehearing Statement" to which was appended a) an October 3, 2011 Behavioral Supports Summary (Ex. 1); b) a September 27, 2011 letter from Dr. [redacted], M.D. (Ex. 2); and c) a September 28, 2011 Anchorage School District amended Individual Education Program (IEP) for Claimant (Ex. 4).[4] The Division did not object to consideration of the Behavioral Supports Summary or Dr. [redacted] letter.

At the October 17, 2011 hearing, the Division objected to the late filed IEP on grounds the submission as an exhibit was unfair surprise and that it was irrelevant because the Division did not have the information before it at the time it denied Claimant's application. Ruling on the Division's objection was held in abeyance until the continued hearing on October 26, 2011, to provide the Division time to review the document and give the parties time to prepare to argue the objection. On October 26, 2011, the Hearing Authority ruled the 'surprise factor' concerning the IEP had been overcome with the lapse of time and that the IEP would be considered at the continued hearing.

Claimant's Prehearing Statement supplied a legal theory by which she challenged the Division's denial of her proposed amendment to her plan of care (hereinafter, application). The theory was that Claimant was due the acuity rate payment because it was authorized by the Medicaid Early and Periodic Screening, Diagnosis and Treatment program (EPSDT) described at 42 U.S.C. 1396d(r)(5), even if the payment was not authorized by Alaska Medicaid statutes or regulations.

On October 26, 2011, the Division filed a document titled "Motion in Limine and Memorandum in Support" which argued against hearing Claimant's EPSDT theory in this case.

[4] A) Both exhibits were written by persons who were not made available for testimony or cross-examination. B) Both exhibits were prepared after August 15, 2011 and therefore were not considered by the Division when making its determination to deny the application. C) The Behavioral Supports Summary contains information already provided in the amendment request. D) Dr[redacted] letter consists principally of re-iterated facts otherwise presented by Claimant and of a conclusion predicting the future, without factual justification for the prediction.

The Hearing Authority granted the Division's Motion in Limine (Motion) on October 26, 2011 after hearing argument from both parties and testimony from the Division's Reviewer. The Motion was granted for these reasons. First, the scope of the Fair Hearing is the Division's denial of Claimant's proposed amendment to her plan of care (application) based on the documentation and theories presented to the Division on February 28, 2011 through and including August 15, 2011, the date of its denial.[5] 42 C.F.R. § 431.231(b). Claimant's EPSDT theory was advanced on the first day of the Fair Hearing on October 17, 2011 and was not in any way involved in this case before then.[6] The Division did not consider 42 U.S.C. 1396d(r)(5) (EPSDT) during the process of reviewing, considering or denying Claimant's requested amendment. (Reviewer's testimony) Therefore, Claimant's EPSDT theory is not within the scope of the decision denying Claimant her proposed amendment to her plan of care.

Second, EPSDT services do not fall within the scope of the home and community-based services provided to Claimant through the Alaska Medicaid Waiver program.[7] Although the Department of Health and Social Services is charged with administering the state's Medicaid plan, it would be unfair and unreasonable, under the circumstances, to include consideration of the EPSDT theory within the scope of a hearing concerning the action of a Division not tasked with consideration of EPSDT matters.

Federal Medicaid regulation 42 C.F.R. § 431.244 requires that Fair Hearing decisions be based exclusively on evidence introduced at the hearing. Therefore, this decision does not address Claimant's EPSDT theory.

2. Stipulation of the parties

During the Fair Hearing, the parties stipulated to omit testimony concerning Claimant's past services and discussions concerning them. Each application to amend a plan of care must be reviewed on its own merits in light of all the (current) facts applicable to the requested amendment. 7 AAC 130.230(g). The Hearing Authority accepted the parties' stipulation 1) that the Division's Reviewer's

[5] Although not stated as part of the Hearing Authority's ruling on October 26, 2011, Federal Medicaid regulation 42 C.F.R. § 431.231(b) states the Fair Hearing "must cover … (b) Agency decisions regarding changes in the type or amount of services;…." The Division's decision did not consider the EPSDT theory, as stated above. Therefore the EPSDT theory is not within the scope of a Fair Hearing authorized by this Medicaid regulation, and need not be considered in this case. The Fair Hearing is administered as authorized by regulation 7 AAC 130.205(i), which provides individuals "denied home and community-based waiver services" opportunity to appeal the decision under 7 AAC 49.

[6] Although it is impermissible for Claimant to assert she is due benefits under a program and/or theory not brought forth before the Fair Hearing, Claimant is not foreclosed applying for Medicaid benefits under the EPSDT theory and therefore is not without remedy. Also, during the Fair Hearing, Claimant mentioned in argument the possibility of discrimination against her as a disabled individual. Claimant did not establish her argument as an issue at the hearing. She did not provide facts supporting discrimination nor make a *prima facia* case (that she is a recipient qualified for the services denied to her, that she was excluded from those services by reason of discrimination based on her disability). Claimant did not propose reasonable accommodation based on her mention of discrimination. In short, Claimant's casual mention of possible discrimination was not pursued and she did not raise the matter as an issue to be addressed in this case. *Contrast, Garner v. State, Dept. of Health and Soc. Services*, 63 P.3d 264, 270 (Alaska 2003).

[7] EPSDT services are authorized at Part 441, Subpart B, particularly 42 C.F.R. § 441.50-441.62, whereas home and community-based services and waiver requirements are found at Part 441, Subparts G and H, particularly 42 C.F.R. § 441.300-441.365.

testimony concerning a prior proposed amendment to Claimant's plan of care, including what needed to be provided in support of the proposed amendment, testimony concerning discussions with Claimant during the summer of 2011, and testimony about the Division's actions regarding Claimant's plan of care between April 2011 and August 15, 2011; (found at record 1:54-2:02:33 of October 17, 2011), and 2) would be stricken from the evidentiary record and that Exhibits G and E-3 would not be admitted.

SUMMARY OF DECISION

On August 15, 2011, the Division was correct to deny Claimant's proposed amendment to her plan of care (application) requesting 72 units of acuity rate add-on payment to her group-home. The Division was correct to determine Claimant was not a qualified recipient whose plan of care was developed and approved under 7 AAC 130.230 documents and requires that she receive dedicated one-on-one staffing 24 hours per day. The Division correctly determined Claimant's needs require additional behavioral analysis and training and do not require a dedicated one-on-on companion 24 hours a day. The Division correctly determined that Claimant has not fully used third-party resources as required by 7 AAC 160.200 and is not entitled to the acuity rate of payment on this basis also. The Division incorrectly denied Claimant's application on grounds that receipt of the acuity rate of payment would necessarily and impermissibly conflict with benefits paid otherwise, because it incorrectly determined that Claimant was required to need dedicated staff "every hour" before she could obtain payment of the acuity rate.

ISSUE

On August 15, 2011, was the Division correct to deny Claimant's proposed amendment (application) to her existing plan of care that requested payment to her group-home of an acuity rate for 72 units (72 days)?[8] The underlying issue is if the Division was correct to determine Claimant's plan of care did not "document and require that the recipient receive dedicated one-on-one staffing 24 hours per day." The outcome of the underlying issue determines the outcome of the primary issue.[9]

FINDINGS OF FACT

The following facts have been proved by a preponderance of the evidence and support the decision.

A. Background

1. Claimant was diagnosed in September 2009 by Anchorage School District as part of an Individual Education Plan (IEP), and in October 2010 by staff at [redacted] Youth Center. (Ex. E. p. 6) Claimant's primary diagnoses were autism, obsessive-compulsive disorder, generalized anxiety

[8] Claimant's application also requested day habilitation and residential habilitation service group home units, which were not denied and are not at issue. *See* Ex. D. 1.

[9] That is, if the Division correctly determined Claimant did not require a one-on-one attendant dedicated to her 24 hours per day, then it would be correct to not authorize the acuity rate additional payment. The acuity rate is also called the "acuity add-on" because it is a Medicaid payment in addition to the regular Medicaid payment made to the group home. The acuity rate is paid to the recipient's group home to provide the one-on-one staff person dedicated to the recipient.

disorder, and depressive disorder not otherwise specified (NOS). (Ex. E, p. 6) Claimant's secondary diagnosis was borderline intellectual functioning. (Ex. E, p. 6) Claimant's IQ is 62 as reported on her September 28, 2011 IEP. (Ex. 4, p. 4)

2. In 2010, Claimant[10] was 18 years old[11], read at a 2.3 grade level, spelled at a 2.8 grade level and did math at a 4.5 grade level. (Ex. E, pp. 5, 8) A Division of Senior and Disabilities Services (SDS) diagnosis evaluation in 2010 disclosed Claimant's "adaptive behavior overall age equivalent" was three years, six months." (Ex. E, pp. 26, 29) The evaluating diagnosis disclosed that Claimant needed "extensive personal care and/or constant supervision." (Ex. E, pp. 26, 30)

3. In February 2010, Claimant was discharged from Alaska Psychiatric Institute to [redacted] Residential Treatment Center in [redacted] where she resided and received treatment for 9 months. (Father's testimony) Claimant was discharged on November 1, 2010 because the Center does not treat individuals 18 years and older, and Claimant became 18 on [redacted], 2010. (Ex. E, pp. 7, 28; Father's testimony)

4. Upon discharge from [redacted] on November 1, 2010, Claimant returned to live with her family in [redacted], Alaska and attended [redacted] High School. (Mother's testimony; Father's testimony) Between November 2010 and March 2011, Claimant lived at her family home. This was difficult for her family because Claimant would hit other family members and wander around the house at night when she did not sleep through the night. (Mother's testimony; Father's testimony) Claimant was suspended from [redacted] High School because of aggression. (Mother's testimony)

5. In March 2011, Claimant was transferred from [redacted] High School to Alaska Psychiatric Institute (API) because she threatened to hurt her teacher. (Mother's testimony) Claimant did not return to the high school and remained at API until early to mid-April 2011. At that time she was discharged to a group home in Anchorage, under the auspices of Hope Community Resources. (Ex. F, pp. 3-4; Mother's testimony)

6. During summer 2011 Claimant did not attend summer school but she participated in Hope's day habilitation program. (Mother's testimony) Claimant did not like the Day Habilitation group activities she attended during summer 2011 but she did enjoy outings into the community with a group home staff person and a housemate. (Mother's testimony) The group home staff may call Claimant's mother once or twice a week concerning Claimant's behavior. (Mother's testimony) The group home has an alarm which will sound if Claimant tries to go out the door. (Mother's testimony) In recent years, Claimant has become more aggressive and sometimes persists in trying to be with males she is attracted to. (Father's testimony)

7. On or about August 16, 2011, Claimant began attending the Anchorage School District Academic and Community Training (ACT) school, which provides extended education for the 18-22 year old Developmentally Delayed population. (Reviewer's testimony) ACT provides schooling subsequent to high school that focuses on self-help, socializing, work experience, academics and

[10] Claimant did not appear or testify at the hearing. In this decision, all references to representations by Claimant are to the testimony of Claimant's parents, who testified on her behalf.

[11] Claimant was 18 years old at the time of the proposed amendment and hearing. She had her 19th birthday on [redacted] 2011.

occupational training. (Reviewer's testimony) Claimant receives 27.5 hours of services at school, including 2 hours per week vocational training. (Ex. 4, pp. 2, 25-26) Claimant works doing light janitorial duties at the [redacted] about 1-2 hours per day, 1-3 days per week. (Ex. 4, p. 5)

8. In spring 2011, while at the group home, Claimant lived with two other girls. (Mother's testimony) Claimant has threatened to hit or hurt the other girls and/or staff, and has been stopped by intervention of a group home caregiver/staff. (Mother's testimony; Ex. F, pp. 4-5) Claimant has not visited her family home since living at the group home because she does not want to visit her family. (Mother's testimony) Her mother and father keep in contact by telephone. (Mother's testimony)

B. Medicaid Home and Community-Based Services (HCBW or Waiver) – Initial Plan of Care

9. Claimant applied for Medicaid benefits through the Alaska Medicaid Home and Community-Based Services Waiver program (Waiver) in anticipation of her discharge from the [redacted] Residential Treatment Facility on November 1, 2010. (Ex. E)

10. The Division of Senior and Disability Services (Division) authorized Claimant to receive Medicaid Waiver benefits, according to an approved plan of care beginning November 1, 2010 and continuing until October 26, 2011 (hereinafter, plan of care). (Ex. E, p. 4, 5)

11. This initial plan of care, effective November 1, 2010, contemplated Claimant would need a group home setting to address her needs. It also contemplated that Claimant would be receiving Medicaid services during the interim period she was living in her family home before moving into a group home suitable for her. (Ex. E, p. 7, 10-11)

12. On December 22, 2010, Hope Community Resources submitted a letter to SDS in support of the Claimant's plan of care stating that at a group home "[s]taff will be provided 24 hours per day, and there will be a person at all times who is available to follow [redacted] should she choose to leave the home as she historically continues to do. The home will have alarms installed on all exit doors." (Ex. E, p. 31)

13. Claimant was approved for Home and Community-Based Waiver, Group Home services beginning April 1, 2011 and continuing until October 26, 2011. (Ex. E, p. 11; Ex. F, p. 3) At the group home, "[s]hift model staffing pattern, meaning three staff members, each having an 8 hour shift every 24 hours, and awake night staff" would be provided. (Ex. E, p. 19; Reviewer's testimony)

14. The initial plan of care provided Claimant with the following services between November 1, 2010 and October 26, 2011:

> a) A care coordinator to advocate for Claimant and visit with her a minimum of twice a month. (Ex. E, p. 9)
>
> b) Ten (10) hours per week respite care for Claimant's family, and 14 days per year daily respite care "to support [Claimant] until an appropriate group home setting can be secured" while "allowing her family time away…." (Ex. E, pp. 9-10)
>
> c) Twenty-five (25) hours per week of Hope Community Resources Day Habilitation between December 1, 2010 and March 31, 2011. (Ex. E, p. 16)

d) Group Home residential services 7 days a week, beginning April 1, 2011 through October 26, 2011. (Ex. E, p. 11)

e) Sixteen (16) hours per week of Hope Community Resources Day Habilitation between April 1, 2011 and October 26, 2011, the period Claimant was approved for group home residency. (Ex. E, p. 16)

15. Claimant's initial plan of care also provided "Special Education Services 32.5 hours per week, 36 weeks per year." (Ex. E, p. 20) Through the special education services, Claimant would receive the full panoply of services available through the Individuals with Disabilities Education Act (IDEA). (Reviewer's testimony) These would include related services such as help from the school psychologist, a positive behavior plan through the school team, functional behavior analysis, occupational therapy designed to address Claimant's sensory issues pertaining to grooming and hygiene. (Reviewer's testimony) Subsequent to the plan of care, Claimant transferred to ACT. (*See* Finding of Fact 7 and Ex. 4) While at the Academic and Community Training (ACT) school, Claimant "would have significantly higher level" professional services available to her than she would receive the rest of her day. (Reviewer's testimony)

C. Identified Behavior Supporting Services Received in Initial Plan of Care

16. The behaviors exhibited by Claimant which supported the group home services she sought in her initial plan of care, were stated as follows, in relevant part:

> [Claimant] is now 18 and needs to have 24 hour daily awake staff support in a community setting to ensure her continued safety. … [Claimant] needs a setting with support at all times she is home from school and throughout the night. She needs a great deal of coaching and support to complete personal hygiene skills. She needs help to work on communication and other social skills. [Claimant] needs support to make sure she has meaningful activities in the home and assistance to learn to help with the general housekeeping. [Claimant] needs a home with monitoring at all times since she has a long history of trying to run away from home during the day and during the night. [Claimant] has very poor safety skills and is at risk of being victimized and harmed because of this. Staff will need to make sure she does not go outside without an escort at any time. [Claimant] has issues of aggression towards others when things are not going the way she would like them. [Claimant] and her staff will need support from Hope Community Resources Behavior Management team. (Ex. E, p. 11)

17. Claimant's needs from a group home identified in her initial plan of care included:

a. "24 hour daily awake staff support in a community setting to ensure her continued safety." (Ex. E, p. 11)

b. "[A] setting with support at all times she is home from school and throughout the night." (Ex. E, p. 11)

c. "She needs a great deal of coaching and support to complete personal hygiene skills." (Father's testimony; Ex. E, p. 11)

d. "She needs help to work on communication and other social skills." (Ex. E, p. 11)

e. Claimant "needs support to make sure she has meaningful activities in the home and assistance to learn to help with the general housekeeping." (Ex. E, p. 11)

f. Claimant "needs a home with monitoring at all times since she has a long history of trying to run away from home during the day and during the night. (Ex. E, p. 11; Father's testimony; Mother's testimony) "Staff will need to make sure she does not go outside without an escort at any time." (Ex. E, p. 11)

g. Claimant "has very poor safety skills and is at risk of being victimized and harmed because of this." (Ex. E, p. 11) Claimant "[r]eported to have a poor understanding of friendship and dating boundaries. Reported to become 'obsessive' about male peers that she may know very superficially…." (Ex. E, p. 11)

h. Claimant "has issues of aggression towards others when things are not going the way she would like them." (Ex. E, p. 11) "Difficulty with dealing with frustrations." (Ex. E, p. 11)

i. Claimant "and her staff will need support from Hope Community Resources Behavior Management team." (Ex. E, p. 11)

18. Claimant's initial plan of care considered the results of an Adaptive Behavior Assessment conducted in Alaska[12]:

> 1. "Hurts self, never, not a problem." 2. "Hurts others, 1-6 times a week, a moderate problem." "Example, hits others. Typical response to problem: physically redirect, remove, or restrain." 3. "Destructive, never, not a problem." 4. "Disruptive, 1-10 times per day, a moderate problem." (Ex. E, p. 29)

D. Application for Payment of the Acuity Rate to Fund a One-on-One Staff Dedicated to Claimant as an Additional Benefit Provided Through Her Plan of Care

19. Claimant submitted a proposed amendment (application) to her plan of care.[13] (Ex. F) The application sought payment of an "Acuity Add-On" of $320 additional daily payment to her Group Home beginning August 16, 2011 through October 26, 2011, a period of 72 days.[14] (Ex. F, p. 3) The proposed amendment was reviewed by Ms. [redacted] (Reviewer), a Health Care Manager III whose work concerns Intellectual Disability and Developmental Disability Services. (Reviewer's

[12] The document may be dated but the copy in the evidentiary record is of such poor quality as not to disclose the date the assessment was conducted. (*See* Ex. E, pp. 26-30)

[13] The date of submission is unclear. Exhibit A, p. 2 states the application was submitted February 28, 2011 but Exhibit F, the application, is date stamped as August 2, 2011, and the Division's Reviewer testified it was received on August 1, 2011. The date of submission is not material.

[14] Claimant's application also sought 72 days of Residential habilitation services at her Group Home and 640 units of Day habilitation services (16 hours per week for the 10 full weeks remaining between August 15, 2011 and October 26, 2011). (Ex. D, p.1) These requests were approved and are not at issue in this case.

testimony) The Reviewer's main task is to review plans of care and amendments to plans of care for individuals seeking Waiver services in light of the applicable regulations.[15] (Reviewer's testimony)

20. Claimant supported her application, in part, by providing a "list of incidents" her group home staff "reported during Claimant's time in her group home setting." (Ex. F, pp. 4-5) The 12 reported incidents spanned from April 16, 2011 through July 27, 2011. (Ex. F, pp. 4-5) The incidents occurred on 9 days:[16] April 16, May 15 (two incidents); June 6, June 14 (two incidents), June 16, June 23, June 26, July 10 (two incidents), and July 27, 2011. (Ex. F, pp. 4-5). The behaviors were described principally as instances of "tantrums" and "physical aggression" (Ex. F, pp. 4-5):

a. The tantrums were described as: "yelling," "screaming," and making verbal threats. (Ex. F, pp. 4-5)

b. The instances of physical aggression were described as "attempting to hit staff with fists," "kicking furniture," punching staff, biting staff, kicking staff, grabbing staff, attempting to hit a housemate, punching a door, slamming a door, and Claimant attempting to remove her own seatbelt and open a car door while the vehicle was moving. (Ex. F, pp. 4-5)

c. During the incidents described on April 16, 2011 and May 15, 2011, a second staff member of the group home was present and assisted. (Ex. F, p. 4)

d. Claimant was responsive to re-directing by staff during each of the incidents, except two. During those two incidents (June 26 and July 27), Claimant stopped her behavior voluntarily.

e. Claimant successfully responded each time the MANDT[17] procedure was used during two incidents on May 15, 2011 and one on June 16, 2011.

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[15] The Reviewer testified she was a Health Care Manager for SDS whose work concerned Intellectual Disability and Developmental Disability Services. Her task is to review plans of care and amendments to plans of care for individuals seeking Waiver services to see if the plans meet regulatory requirements. Her credentials include a Bachelor of Science with dual majors in Education K-8 and Special Education K-12; a Master of Arts degree in Teaching for Adults in Community Education, and a Master of Education in Educational Leadership; Certification K-12-Principal; Certification K-12 Special Education. She is a Graduate of University of California at Riverside with a Certificate in Assistive Technology and Applications. Before becoming the SDS' reviewer of plans of care for Waiver applicants, she taught Special Education grades K-12 for the State of Alaska Anchorage School District for 22 years, primarily grades 7-12. Through this work she became knowledgeable about the supports, programs and services available to recipients of special education/IDEA services. (Reviewer's testimony)

[16] The incidents took place on 9 days out of a possible 102 days, during a span of about 14 and ½ weeks.

[17] The MANDT system teaches "specific non-physical skills to assist and support people to de-escalate… include[ing]specific verbal and non-verbal communication skills, conflict resolution skills," and "a way of using physical interventions which maximizes safety and minimizes risk." "[T]the material taught in The Mandt System®, at a minimum, meets all of the training standards in the Children's Health Act of 2000, Parts H and I (Public Law 106-310, U.S. federal law), the Developmental Services Act, Regulation 272, Part VI (Ontario, Canada), as well as standards developed by organizations such as the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), the Council on

(Ex. F, pp. 4-5)

21. Claimant justified her request for payment of the acuity add-on rate to her group home by re-iterating the justification for group home services that she provided in her initial plan of care.[18] (*Compare* Ex. E, p. 11 with Ex. F, pp. 4-5). However, in Claimant's application to amend her plan of care, she added, in part: "[Claimant] does not do well with transitions into new place. "[Claimant] this next year is transitioning into a new school setting with all new ASD staff to her case, and introducing a new school program … . With the acuity rate staff will be in place to help support "[Claimant] and ASD staff if [Claimant] is unable to participate in school events and needs to go home. Staff will also communicate more with ASD staff to support [Claimant] in her academics. (Ex. F, p. 4) Because Claimant did transition to the ACT school, specifically suited to Claimant's needs and not merely an ASD school providing specialized services through an IEP, this justification does not apply. (*See* Finding of Fact 7)

22. On August 15, 2011, the Division denied Claimant's application for "Acuity Add-On: 72 units (72 days). (Ex. D, pp.1, 4) The Division's denial was based on three factors. (Ex. D)

> a) Claimant's needs do not require a dedicated, one-on-one staff person for 24 hours a day. (Ex. D, p. 2; Reviewer's testimony) Claimant's needs already are addressed by the services she receives, which include direct care and support received at her ACT school, day habilitation, residential habilitation, and group home services. (Ex. D; Reviewer's testimony)
>
> b) Claimant's needs that are not already addressed, if any, can be addressed better by professional services provided through third party resources, including TRICARE,[19] and/or other Medicaid benefits, than by having an attendant dedicated to her 24 hours a day. (Ex. D, p. 2; Reviewer's testimony)
>
> c) Legal requirements pertaining to payment for Home and Community-Based Services as Medicaid Waiver benefits (Waiver) preclude payment of the acuity rate during the same

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Accreditation (COA), CARF, the American Correctional Association (ACA), and all known state regulations." *See* http://www.mandtsystem.com/faq/faq.ms accessed on January 11, 2012.

[18] Some documents identified in the Behavioral Supports Summary, which also are listed as justification for Claimant's request for the acuity rate add-on payment, were not provided for review. These are a Behavioral Support Plan and a Functional Behavioral Assessment. (Reviewer's testimony; *see* Ex. 1,p. 1; Ex. F, pp.3-4) Other documents listed in the application justification are Emergency Response Plan, Interaction Guidelines, Preliminary Recommendations Pre-Intake, and Behavioral Support Assessment. (Ex. F, p. 4) These were not provided as evidentiary exhibits nor discussed in testimony at the hearing. At the hearing, the Reviewer noted that a letter dated October 3, 2011, (Exhibit 1), referenced a Behavioral Support Assessment dated November 17, 2010, and a Functional Behavioral Assessment dated 6/19/11 that had not been provided to the Division. The Reviewer also noted the Division had not received notes of the weekly or bi-weekly meetings of Claimant's behavioral support team, or seen the Behavioral Support Plan referenced in the letter. There is no indication the denial of Claimant's proposed amendment was based on the absence of this documentation.

[19] Claimant's father is a member of the U.S. military and the benefits of the TRICARE military health plan are available to his family and to Claimant. (Father's testimony)

time that other services are being provided and a qualified recipient must require dedicated one-on-one staff each and all of the 24 hours for which the acuity rate is paid. (Ex. D, p. 2 ("to authorize the acuity rate under 7 AAC 145.520(m), a recipient must require DEDICATED staff every hour." [emphasis in original]); Reviewer's testimony)

23. The Division's Reviewer's testimony established the following facts:

a) The Division has adopted the purpose of the Home and Community-Based Services Waiver program as: to provide services and support to persons so they can remain in the community, avoid being institutionalized and be as highly functioning in the community as possible for each individual.

b) The purpose of the Waiver program is to improve the ability of individuals to function in the community through habilitative services, which are designed to address behavior, helping people learn skills, behaviors, and adaptations to improve their ability to be included in the community. The attendant provided by payment of the acuity rate supplies a "behavioral service" of "direct care and support," which differs from supervision.

c) As a behavioral service, the Medicaid Home and Community-Based Waiver regulations require exhaustion of third-party resources prior to authorization of Medicaid payment for the acuity add-on.

d) The Division adopted the acuity rate payment by regulation March 1, 2011. (*See also* 7 AAC 145.520(m)). The Division adopted the acuity add-on specifically to provide dedicated one-on-one staff for direct care and support, 24 hours a day, seven days a week. The acuity rate add-on is payment for a behavioral service to provide direct care and support to help a recipient and not more supervision. Direct care and support is not the same as supervision.

e) In reviewing Claimant's proposed amendment to her plan of care, the Reviewer looked at the underlying plan of care as well as her proposed amendment to it and all the information provided to the Division by the time of review, and based its denial on that information. (Reviewer's testimony)

f) At the time of review, Claimant has not applied for or obtained the full benefit of third party resources, including TRICARE[20] benefits.

g) TRICARE has a specific program available to families with members who have autism spectrum disorder through its extended care health option (ECHO). Through ECHO, families can get up to $36,000 per year of benefits related to applied behavior analysis (ABA) and this is available in Anchorage. Applied behavior analysis would address Claimant's need in regards to "trigger words." Two of the incidents listed in Claimant's

[20] TRICARE is the health care program serving Uniformed Service members, retirees and their families worldwide *See* http://www.tricare.mil

justification (June 14, 2011 and July 10, 2011) resulted from Claimant's staff using "trigger words." Had the staff been trained in applied behavior analysis in relation to Claimant, these incidents likely would not have occurred.

h) Applied behavior analysis and therapy is a behavioral support service that would address Claimant's behaviors, such as her getting up at night, attempting to leave her residence, responding to "trigger" words with aggressive behavior, etc. The applied behavior program would include training Claimant's provider staff, as well as directly teach Claimant adaptive behavior skills. Learning adaptive behavior skills is what Claimant needs, not more or closer supervision.

i) Claimant has not obtained other Medicaid services available to her during the day, including in particular, intensive active treatment services, which would address her needs more appropriately than one-on-one staff providing closer supervision. Intensive active treatment is an alternative Medicaid service provided by high level professionals and is specifically geared to the recipient's behavior and conditions.

j) Another potential service available to Claimant is job related supported employment and/or a job coach. If justified, additional hours of day habilitation could be authorized.

k) The services Claimant receives at school are not related to her behavior of not sleeping through the night. Claimant's needs during school hours are or should be addressed by her school behavior plan.

l) Claimant's existing plan of care authorizes staffing of 24 hours a day, 7 days a week through the Residential Habilitation Group Home service, day habilitation and school program services she receives. (*See also* Ex. D, pp. 1-2) Claimant is provided with awake night staff at the group home and alarms on the door.[21] (*See also* Ex. E, p. 31; Ex. F, p. 14; Mother's testimony) At her group home, Claimant is supervised by a Home Alliance Coordinator (HAC) living in the home 24 hours a day plus two direct service providers. (Reviewer's testimony; *see* Ex. F, p. 4)

m) Claimant's application referenced 12 incidents over a period of 9 days, out of 102 days, during which she manifested tantrums and physical aggression towards others. These incidents represent aggression 40 percent of the time, which is not an overwhelming or significant percentage of time. In addition, these incidents occurred during the period that Claimant had medication changes, started attending a new school and was adjusting to group home living.

n) One of the justifications for Claimant's application for the acuity rate is that Claimant needs someone to be with her to transport her from places when she manifests inappropriate or unacceptable behavior. (*See also* Ex. F, p. 4) Transportation already is provided under the existing plan of care as part of the group-home daily rate of payment. When Claimant misbehaves at school, the school is required to address Claimant's

[21] The Reviewer's testimony corrected the typographic error on Exhibit D, page 2 which states on the first line "with no awake night staff…" making clear Claimant has awake night staff at the group home where she resides.

behavioral needs, and not seek to send her away. Therefore, payment of the acuity rate to provide an attendant to transport Claimant away from school would be impermissible duplication of services.

24. On the first day of hearing, Claimant's parents were unaware whether TRICARE offered benefits available to Claimant. (Mother's testimony) By the second day of the hearing, Claimant's parents had talked with a TRICARE representative but not in sufficient depth to know if TRICARE would pay for any or all of the one-on-one staff they wanted for Claimant. (Claimant's parent's testimony)

PRINCIPLES OF LAW

I. Burden of Proof and Standard of Proof

"Ordinarily the party seeking a change in the status quo has the burden of proof." *State, Alcoholic 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 Paid by the State of Alaska

The State of Alaska provides medical assistance to needy persons who are eligible. AS 47.07.010; AS 47.07.020. It does this, in part, by participating in the national medical assistance program provided by 42 U.S.C. 1396 – 1396p, (Title XIX of the Social Security Act), which provides grants to states for medical assistance programs, including Medicaid. Alaska statute AS 47.07.45 provides home and community-based services under a waiver in accordance with 42 U.S.C. 1396-1396p.

Federal Medicaid regulations, relevant to this case, concerning home or community-based services are found at 42 C.F.R. § 440.180 and 42 C.F.R. § 441.300-310. Regulation 42 C.F.R. § 440.180 states:

> (a) … "Home or community-based services" means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this chapter.
>
> …
>
> (3) The services are subject to the limits on FFP[22] described in § 441.310 of this chapter.

Regulation 42 C.F.R. § 441.310, Limits on federal financial participation (FFP), provides, in relevant part:

[22] FFP is the acronym for Federal financial participation. *See* 42 C.F.R. § 441.310.

> (a) FFP for home and community-based services listed in § 440.180 of this chapter is not available in expenditures for the following:
>
> (3) Prevocational, educational, or supported employment services, or any combination of these services as part of habilitation services that are … (ii) Otherwise available to the recipient under either special education and related services …
>
> (b) FFP is available for expenditures for expanded habilitation services, as described in § 440.180 of this chapter, if the services are included under a waiver or waiver amendment approved by CMS.[23]

The Alaska Department of Health and Social Services administers the home and community-based services Medicaid waiver (Waiver) program by applying AS 47.07.045 and also regulations found in the Alaska Administrative Code (AAC) at Title 7, Chapters 100 – 160.

Thus, home and community-based waiver services (Waiver) means services provided under AS 47.07.045. 7 AAC 160.990(26). One home and community-based waiver services program provides Medicaid benefits to eligible recipients who fall within the category of individuals with mental retardation and developmental disabilities (MRDD).[24] 7 AAC 130.200; 7 AAC 130.205; 7 AAC 140.600.

III. The Alaska Medicaid Home and Community-Based Waiver Services Program Regulations Pertinent to this Case.

The purpose of home and community-based services (Waiver) is to offer a choice between home and community-based 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 130.200.

Medicaid recipients who are eligible for Waiver services must complete a plan of care. 7 AAC 130.230. This regulation describes the plan of care process and requirements, in relevant part:

> (b) If the assessment is to determine if the applicant falls within the recipient category for (1) individuals with mental retardation and developmental disabilities, the (A) department will make a level-of-care determination under 7 AAC 140.600(c)-(d); and (B) level of care determination must incorporate the results of the *Inventory for Client and Agency Planning (ICAP)*, ….

[23] CMS is the acronym for Centers for Medicare and Medicaid Services.

[24] The HCBW services program serves four primary categories of Medicaid recipients: a) aged; b) blind; c) physically or developmentally disabled; and d) mentally retarded persons. 7 AAC 130.200. Alaska has variously named programs for recipients of each category. E.g., Adults with Physical Disabilities (APD); Children with Complex Medical Conditions (CCMC); Mentally Retarded (now Intellectual) and Developmental Disabilities (MRDD); and Older Alaskans (OA). *See* www.hss.state.ak.us/dsds/grantservices/hcbwaivers.htm.

(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.

(d) If a plan of care is for a recipient who falls within the recipient category … for individuals with mental retardation and developmental disabilities, (1) the care coordinator shall convene a comprehensive planning team to participate in preparing the plan of care; (2) the comprehensive planning team must consist of the (A) recipient; (B) recipient's (i) family members, including parents, siblings, and others similarly involved in providing general oversight of the recipient; or (ii) legal guardian, if any; (C) care coordinator; and (D) enrolled providers that are expected to provide services; ….

(f) The department will approve a plan of care if the department determines that each service listed on the plan of care (1) is of sufficient amount, duration, and scope to prevent institutionalization; (2) is supported by the documentation required in (c)(4) of this section; and (3) cannot be provided under 7 AAC 105 - 7 AAC 160, except as a home and community-based waiver service under 7 AAC 130.200 - 7 AAC 130.319.

(g) …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 the department determines that adequate documentation is not provided, the department may cap service levels at prior year levels, or reduce service levels to reflect the recipient's historical usage . . . . The department will approve changes to a plan of care if the department determines that (1) the amount, scope, and duration of services to be provided will reasonably achieve the purposes of the plan of care, and are sufficient to prevent institutionalization; (2) each service to be provided is supported by documentation as required by (c)(4) of this section; and (3) the services to be provided are not otherwise covered under 7 AAC 105 - 7 AAC 160, except as a home and community-based waiver service under 7 AAC 130.200 - 7 AAC 130.319.

Medicaid payments for Waiver services are varied and numerous. For example, see 7 AAC 130.240-305. The Department of Health and Social Services administers the Medicaid program in Alaska. AS 47.07.030(a) ("The department shall offer all mandatory services required under 42 U.S.C. 1396 – 1396p…."

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

This case involves the Home and Community-Based Services Waiver program for the Mentally Retarded / Developmentally Disabled ("MRDD)." Qualified recipients may be eligible for benefits authorized by a number of Medicaid regulations.

A. Federal Statutes and Regulations.

The Medicaid MRDD waiver program's objective is to avoid placing a qualified individual in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) if necessary services are available in the community. *See* 42 U.S.C. § 1396a(a)(10)(A)(ii)(VI); 42 C.F.R. § 441.301(b)(1)(ii) and (iii)(B); 42 C.F.R. § 430.25(c)(2). In order to qualify under the federal regulations, the applicant must have a need for the level of care provided in an ICF/MR. *See* 42 C.F.R. § 440.150. In addition, it must be determined that, but for the waiver, the applicant would be institutionalized in such a facility. *See* 42 C.F.R. § 441.302.

42 U.S.C. § 1396n(c)(5)(A) defines "habilitative services" within the context of state waiver programs for preventing the institutionalization of the mentally retarded. Under this section, "habilitation services" are "services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings."

B. State Regulations.

Alaska's regulations for administration of the Waiver 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."

1. 7 AAC 130.205 Regulation 7 AAC 130.205 provides that "for the Department to make payment under Medicaid for home and community-based waiver servicers provided to an individual" the individual must be eligible for coverage, and the services for which the individual is eligible must be services provided by applicable regulations of 7 AAC 130.200-7 AAC 130.319. 7 AAC 130.205(a). There are other requirements at subsections (b) through (h). Regulation 7 AAC 130.205(c) provides that a person receiving Waiver services "is eligible to receive other Medicaid services for which the recipient is otherwise eligible."

More particularly, 7 AAC 130.205(f) specifies that Waiver services are payable only after a plan of care is approved as provided in 7 AAC 130.230 and a provider has the capacity to provide the service levels identified in the individuals' plan of care.

2. 7 AAC 130.230 Regulation 7 AAC 130.230 is titled "Screening, assessment, plan of care and level-of-care determination." This regulation requires an applicant for Waiver services to undergo an initial screening from a care coordinator to determine if an assessment is warranted, obtain an assessment to determine if the recipient falls into one of the four categories of persons for whom Waiver services are available, and to complete a plan of care approved by the department.

Regulation 7 AAC 130.230(c) specifies a detailed list of duties the care coordinator must address in fashioning a plan of care, which then is presented to the department for consideration and approval.

There are additional regulations pertaining to Waiver services particularly applicable to persons diagnosed as Mentally Retarded / Developmentally Disabled ("MRDD").[25] If the individual falls within the category of persons with mental retardation and developmental disabilities, as in this case, a "comprehensive planning team" is required to collaborate in preparing the plan of care. 7 AAC 130.230(d).

Once a plan of care has been prepared, regulation 7 AAC 130.230(f) provides, in part:

> The department will approve a plan of care if the department determines that each service listed on the plan of care (1) is of sufficient amount, duration, and scope to prevent institutionalization; (2) is supported by the documentation required in (c)(4) of this section; and (3) cannot be provided under 7 AAC 105 - 7 AAC 160, except as a home and community-based waiver service under 7 AAC 130.200 - 7 AAC 130.319.

If an approved plan of care is sought to be amended, regulation 7 AAC 130.230(g) applies.

> 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.
>
> …
>
> The department will approve changes to a plan of care if the department determines that (1) the amount, scope, and duration of services to be provided will reasonably achieve the purposes of the plan of care, and are sufficient to prevent institutionalization; (2) each service to be provided is supported by documentation as required by (c)(4) of this section; and (3) the services to be provided are not otherwise covered under 7 AAC 105 - 7 AAC 160, except as a home and community-based waiver service under 7 AAC 130.200 - 7 AAC 130.319.

[25] "MRDD" is being re-named to "Intellectually Disabled/Developmentally Disabled" ("IDD") at federal and state levels. ([redacted] testimony) Three other groups eligible for Waiver services are: Adults with Physical Disabilities ("APD"), Children with Complex Medical Conditions ("CCMC"), and Older Alaskans ("OA"). *See* 7 AAC 130.230.

3. Regulations authorizing various services to individuals with mental retardation or developmental disabilities within Claimant's age category

a. 7 AAC 130.260 - Day habilitation services
b. 7 AAC 130.265 - Residential habilitation services
c. 7 AAC 130.270 - Supported-employment services
d. 7 AAC 130.275 - Intensive active treatment services
e. 7 AAC 130.280 - Respite care services
f. 7 AAC 130.290 -Transportation services
g. 7 AAC 130.295 - Meals services
h. 7 AAC 130.300 - Environmental modification services
i. 7 AAC 130.305 - Specialized medical equipment and supplies

The department will pay for day habilitation services that are provided to individuals with mental retardation or developmental disabilities, if they are approved as part of the recipient's plan of care and do not replace, enhance, or supplement educational services for which the recipient is eligible under 4 AAC 52 (Intellectual and Disabilities Education Act[IDEA]). 7 AAC 130.260.

Regulation 7 AAC 130.260, titled "Day Habilitation Services," provides in relevant part as follows:

> (b) The department will consider habilitation services to be day habilitation services if they
>
> > (1) take place in a nonresidential setting, separate from the home, assisted living home licensed under AS 47.32, or foster home licensed under AS 47.32 in which the recipient resides . . . ; for purposes of this paragraph, day habilitation services include transportation of the recipient between the home… where the recipient resides and the site where the services are provided; and
> >
> > (2) do not replace, enhance, or supplement educational services for which the recipient is eligible under 4 AAC 52.[26]

Regulation 7 AAC 130.265 " Residential habilitation services" provides payment for services that are provided to individuals with mental retardation or developmental disabilities, among others, if approved as part of the recipient's plan of care (approved under regulation 7 AAC 130.230) and previously authorized. Group home habilitation services are a form of residential habilitation services. 7 AAC 130.265(b)(4). Payment for residential habilitation services is made for group-home habilitation services. (7 AAC 130.265(b)(4)), among other types of services.

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[26] Regulations at 4 AAC 52 refer to Title 4 Education and Early Development, Chapter 52 Education for Children with Disabilities and Gifted Children of the Alaska Administrative Code. Alaska implements the Individuals with Disabilities Education Act (IDEA), a law ensuring services to children with disabilities. IDEA governs how states and public agencies provide early intervention, special education and related services to more than 6.5 million eligible infants, toddlers, children and youth with disabilities. Children and youth (ages 3-21) receive special education and related services under IDEA, Part B. *See* http://idea.ed.gov .

Regulation 7 AAC 130.319(3) defines habilitation services as

> services that help recipients acquire, retain, or improve skills related to activities of daily living and self-help, social, and adaptive skills necessary to enable the recipient to reside in a noninstitutional setting that is provided in a recipient's home, a shared-care environment, an assisted living home licensed under AS 47.32, or a foster home licensed under AS 47.32.

4. 7 AAC 160.200 Regulation 7 AAC 160.200 provides: "The department will pay for a service, prescription drug, or supply only to the extent it is a covered service under AS 47.07.30 and 7 AAC 105 – 7 AAC 160 and only after the recipient has made full use of any other third-party resources available to pay for that service, prescription drug, or supply."

5. 7 AAC 145.520(m) Acuity Rate Supplement – The Regulation Subject to Interpretation in this Case

Regulation 7 AAC 145.520 is titled "Home and community-based waiver services payment rates." On March 1, 2011, regulation 7 AAC 145.520(m) was adopted.[27] This regulation states:

> A qualified recipient receiving … group-home habilitation services under 7 AAC 130.265 that are assigned procedure code T2016 in the *Healthcare Common Procedure Coding System*, is eligible for an acuity daily rate of $320 per approved day in addition to the qualified recipient's daily rate provided for under (f) and (h) of this section. For purposes of this subsection, a qualified recipient is a recipient whose plan of care developed and approved under 7 AAC 130.230 documents and requires that the recipient receive dedicated one-on-one staffing 24 hours per day.

Regulation 7 AAC 145.520(m) was adopted March 1, 2011 and established an acuity add-on payment providing for dedicated one on one staff for qualified recipients. The Division's first Policy and Procedure Manual policy memorandum, dated February 18, 2011, was suspended by the Division policy memo dated August 5, 2011. The department does not have a policy interpreting this regulation. None of the policy memoranda discussed if the acuity rate would be paid solely as a block of 24 hours or hourly.[28] The regulation language does not state the acuity rate must be paid for all 24 hours of a day.

[27] It appears the former 7 AAC 145.520(m) was repealed entirely. Current regulation 7 AAC 145.520(m) is substantially differently worded.

[28] *See* http://www.hss.state.ak.us/dsds/policies/PDFS/SuspendedAcuityRates21711.pdf

ANALYSIS

I. Issue

On August 15, 2011, was the Division correct to deny Claimant's proposed amendment (application) to her existing plan of care that requested payment to her group-home of an acuity rate for 72 units (72 days)? The underlying issue is if the Division was correct to determine that Claimant's plan of care did not "document and require that the recipient receive dedicated one-on-one staffing 24 hours per day." The outcome of the underlying issue determines the outcome of the primary issue.

II. Burden of Proof and Standard of Proof

Claimant seeks additional Medicaid benefits in the form of the acuity rate add-on Medicaid payment by applying to amend her plan of care.[29] Therefore, Claimant is seeking to change the status quo and to obtain more benefits. For both these reasons, Claimant bears the burden of proving she is eligible for the benefits she seeks. "Ordinarily the party seeking a change in the status quo has the burden of proof." *State, Alcoholic Beverage Control Board v. Decker*, 700 P.2d 483, 485 (Alaska 1985) (also ruling that applicants who seek benefits carry the burden of proving they are eligible for the benefits they seek)

Claimant must prove by a preponderance of the evidence that her application for a change in her plan of care documents her needs such that she requires that she receive dedicated, one-on-one staffing 24 hours per day. 7 AAC 145.520(m).

III. Regulation 7 AAC 145.520(m)

The parties dispute if Claimant's needs make her a qualified recipient of the acuity rate of payment provided by regulation 7 AAC 145.520(m). The regulation states, in relevant part:

> A qualified recipient receiving … group-home habilitation services under 7 AAC 130.265 that are assigned procedure code T2016 in the *Healthcare Common Procedure Coding System*, is eligible for an acuity daily rate of $320 per approved day in addition to the qualified recipient's daily rate provided for under (f) and (h) of this section.

Particularly, the parties dispute if Claimant's proposed amended plan of care (application) "documents and requires" that Claimant receive the acuity daily rate, as provided in the remainder of this regulation:

[29] Claimant argued in Claimant's Initial Post-Hearing Memorandum, at 11, that the Division should bear the burden of proof because "this case involves a planned retreat from an existing level of services…." However, 1) the parties stipulated to strike evidence pertaining to what would be included in the phrase "planned retreat" from past services; 2) 7 AAC 130.230(g) requires changes to a plan of care to be considered on their own merit; and 3) Claimant's initial plan of care provided for services paid by regular Medicaid benefits and not by the acuity rate of payment, thereby making Claimant's request for the acuity rate an application for a new benefit.

> For purposes of this subsection, a qualified recipient is a recipient whose plan of care developed and approved under 7 AAC 130.230 documents and requires that the recipient receive dedicated one-on-one staffing 24 hours per day.

IV. Proposed Amendments to a Plan of Care Are Governed by Regulation 7 AAC 130.230

First, Claimant must show that her proposed amendment to her plan of care meets the requirements for a change in plan of care. Regulation 7 AAC 130.230(g) applies to changes to plans of care, stated in relevant part as:

> (g) …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 the department determines that adequate documentation is not provided, the department may cap service levels at prior year levels, or reduce service levels to reflect the recipient's historical usage . . . . The department will approve changes to a plan of care if the department determines that (1) the amount, scope, and duration of services to be provided will reasonably achieve the purposes of the plan of care, and are sufficient to prevent institutionalization; (2) each service to be provided is supported by documentation as required by (c)(4) of this section; and (3) the services to be provided are not otherwise covered under 7 AAC 105 - 7 AAC 160, except as a home and community-based waiver service under 7 AAC 130.200 - 7 AAC 130.319.

Thus, Claimant's application must provide sufficient documentation of her need for the benefits she seeks. Although the Division's Reviewer testified she had reviewed all the information provided by Claimant in support of her application and that some documentation referenced as submitted had not been received, the issue in this case is not that there was insufficient documentation. The issue is whether the documentation provided supported Claimant's asserted needs proving she "required" dedicated, one-on-one staffing to meet her needs.

V. Facts

A. Applicability of 7 AAC 145.520(m) to Undisputed Facts.

The parties did not dispute that Claimant is recipient of group-home habilitation services under 7 AAC 130.265 that are assigned procedure code T2016 in the Healthcare Common Procedure Coding System, and that she falls within the categories of Medicaid recipients potentially eligible for the acuity rate authorized by 7 AAC 145.520(m).

The parties did not dispute that Claimant is receiving group-home habilitation services as a Medicaid recipient through the Home and Community- Based Services (Waiver) program pursuant to 7 AAC 130.200-7 AAC 130.319, in particular within the category of recipients experiencing developmental disabilities (MR/DD), and therefore is subject to laws and regulations applicable to that category of persons.

B. Facts Concerning Claimant's Needs

The Division asserts Claimant's needs are already met in a manner sufficient to keep her from becoming institutionalized and to address her safety issues. The Division asserts the benefits Claimant is authorized are sufficient because she receives residential habilitation services 24 hours a day, 7 days a week as a member of her group-home. In addition, when she is away from home Claimant receives one-on-one staff through day habilitation services. The remainder of the time she is at her specialized ACT school.

Claimant asserts she needs the additional services provided by a one-on-one staff (attendant) dedicated solely to her needs. Claimant asserts she requires an attendant, to keep herself and others safe.

The parties do not dispute that Claimant needs services 24 hours a day, 7 days a week. This is supported by the facts. *See* Finding of Fact 1 through 8; 16-18; and 20. The difference between the parties' arguments is that Claimant's present support is not dedicated exclusively to Claimant at all times.

The dispute between the parties can be characterized as one where Claimant asserts she needs one-on-one dedicated staff available to control her behavior so she and others remain safe. In contrast, the Division asserts Claimant needs to learn adaptive behavioral skills so her behavior does not make her or others unsafe. Otherwise stated, Claimant seeks the acuity rate add-on to pay for someone to control her behavior, whereas the Division asserts that services and programs, also paid by Medicaid, will better address Claimant's safety issues because they will teach Claimant self-control.

Claimant reported 12 incidents during which she manifested tantrums and physical aggression. The reported incidents document her aggressive behavior was controlled, but not prevented. Claimant seeks an attendant to potentially enhance external control of her behavior. The Division argues Claimant requires additional behavioral skills to enhance her self-control. The Division's position is that present services and programs, and possible supplemental services (not paid through the acuity rate), will teach Claimant adaptive behaviors enabling her and others to be safe from her aggression, and, in effect, prevent her misbehavior. The Division's Reviewer asserted existing and potential services also would teach those who provide services to Claimant how to deal with her consistently in a manner supporting her safety and that of others.

VI. Claimant is Not a Qualified Recipient as Described by 7 AAC 145.520(m).

Regulation 7 AAC 145.520(m) states, in part: "a qualified recipient is a recipient whose plan of care developed and approved under 7 AAC 130.230 documents and requires that the recipient receive dedicated one-on-one staffing 24 hours per day."

The Division denied Claimant's application, in part, because it determined Claimant did not "require" dedicated one-on-one staffing 24 hours per day. Claimant asserts she needs an attendant focused on her twenty-four hours a day, seven days a week, in addition to the other persons who address her needs, to ensure that she remains safe and is not a danger to others. Included in the issue of her safety, but addressed separately below, is Claimant's claim that she is likely to run away from those caring for her and become exposed to dangers while unescorted in the community.

Claimant is now 19 years old and during the day attends the ACT school that provides specialized classes in self-help, socialization, occupational training and work experience, as well as academics to persons 18-22 with developmental delays. When not in school or at her group home, Claimant receives day habilitation during which she is involved in the community as part of a small group or one-on-one with a staff person. The rest of the time, Claimant is in the care of staff from her group home and/or at the group home.

Claimant's "adaptive behavior overall age equivalent" was evaluated as the age of three years six months. As described in the reported incidents, Claimant's aggression occurred when "things are not going the way she would like them" and when she had difficulty dealing with frustrations. Her aggressions consisted of kicking, grabbing, hitting, and biting. These are behaviors typical of children of Claimant's adaptive behavior age. However, Claimant's IQ is 62. She is able to learn. *See* Finding of Fact 2. During two of the reported 9 incidents of aggressive behavior, on June 26, 2011 and July 27, 2011, Claimant voluntarily stopped her inappropriate behavior.

Claimant argued she needs an attendant to be focused on her at all times and places to keep herself and others safe from her physical aggression. She argued she needs an attendant to "take steps to keep things from going wrong"[30] and be "familiar with her needs and able to respond to her." [31] She points to 12 incidents over a period of 9 days, out of 102 days, during which she manifested tantrums and physical aggression towards others. The Division's Reviewer testified these incidents represented aggression 40 percent of the time, which she believed was not an overwhelming or significant percentage of time under the circumstances that Claimant had medication changes, started attending a new school and was adjusting to group home living during the same period.

Claimant did not explain how having a companion would stop her from manifesting her tantrums and aggression or protect her and others when she did manifest aggression. Claimant did not explain if the attendant would be expected to exercise physical control over her and did not suggest the attendant should be a body-guard to physically restrain her from manifesting unsafe behaviors. During three of the reported incidents, the MANDT[32] techniques, which may include physical restraint, were successfully applied to Claimant. *See* Finding of Fact 20. Claimant's purpose in having a dedicated 24 hour attendant is to supervise, if not control, Claimant's behavior to address safety concerns, but it is unclear how the attendant would be better able to keep Claimant and others safe than the professionals from whom Claimant receives daily services.

The Division's Reviewer testified the attendant provides a "behavioral service" of "direct care and support," which differs from supervision. The Division argued, in essence, that Claimant would benefit more from learning adaptive behaviors and receiving intensive active treatment that would prevent her from acting aggressively, than from receiving the "direct care and support" an attendant would provide, to try to control her misbehavior.

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[30] Claimant's Initial Post-Hearing Memorandum at 1.

[31] Claimant's Initial Post-Hearing Memorandum at 5
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[32] See Footnote 12, hereinabove.

The Division's argument is persuasive. Claimant argues against herself. Claimant proved her attendance at school and the object of her day habilitation are to help her learn more coping skills and behaviors to better enable her to live in the community and stay out of an institution. The focus of nearly all the Medicaid benefits and programs Claimant receives is to teach her how to cope in the community and manifest appropriate behavior, including safe behavior. Claimant did not prove that she is not able to learn better coping and adaptive behaviors. Claimant did not prove she is required to have an attendant to ensure her behavior is controlled and safe because the existing support she has is ineffective. The reported incidents proved Claimant's aggression was controlled by her existing support staff; and, as noted, that Claimant was able to voluntarily "self-control" and stop her aggressive behavior. Claimant has not proved, by a preponderance of the evidence, that her needs require a dedicated one-on-one staff 24 hours a day to keep her and others safe and to keep her out of an institution due to her aggressive behavior.

Claimant also argued she needs an attendant 24 hours a day to prevent her from running away from buildings and into the street where she may encounter circumstances with which she is not able to cope; i.e., danger from vehicles and danger from strangers who may take advantage of her. During the Fair Hearing, a particular emphasis was her nighttime wandering and the possibility she would leave her group-home at night. This type of need is a need for supervision and not need for "direct care and support."

At her group home, Claimant is supervised by a Home Alliance Coordinator (HAC) living in the home 24 hours a day plus two direct service providers. During the night, there is an awake night staff at her group home. There is an alarm on the door which will sound should Claimant open the door. In this regard, the attendant would provide another person to do the same job already being done by others and by technology. Thus, Claimant already is supervised 24 hours a day, seven days a week, while she is at her group home. Also, Claimant has professionally trained persons supervising her while she is in school and is supervised either one-on-one, or nearly so, during day habilitation activities. Therefore, Claimant did not prove by a preponderance of the evidence that she requires a dedicated one-on-one attendant to prevent her from going un-escorted into the community.

Finally, at the heart of the Home and Community-Based Services Waiver program is the requirement that the services and benefits obtained be required and for the purpose of preventing the individual from needing institutional care. Claimant has not proved by a preponderance of the evidence that without receipt of the dedicated, one-on-one attendant 24 hours a day she will have to live in an institution.

Therefore, the Division was correct to determine Claimant was not a qualified recipient eligible for payment

VII. Third Party Resources: 7 AAC 160.200

The Division also denied Claimant's application because Claimant had not fully used all third-party resources before seeking the acuity rate payment.

Regulation 7 AAC 160.200(a) provides: "The department will pay for a service, prescription drug, or supply only to the extent it is a covered service under AS 47.07.30 and 7 AAC 105 – 7 AAC 160 and only after the recipient has made full use of any other third-party resources available to pay for that service, prescription drug, or supply." Regulations 7 AAC 105 - 7 AAC 160 pertain to Medicaid coverage and payment. Alaska Administrative Code, Title 7, Part 8. Regulation 7 AAC 160.200(b) provides examples of third-party resources and includes "(4)(B) the TRICARE military health plan under 10 U.S.C. 1071" among other resources.

The Division provided persuasive evidence that Claimant could obtain benefits through the TRICARE system. The Division's Reviewer described the ECHO program, provided through TRICARE, which offers an extended health care service program of up to $36,000 per year for applied behavioral analysis (ABA) and the intensive active treatment services authorized by regulation 7 AAC 130.275, as alternatives to an attendant paid by the acuity rate. These services would directly assist Claimant to learn additional adaptive behaviors during the daytime hours.

In contrast, Claimant provided evidence that she had not fully explored the benefits available to her through TRICARE. Claimant did not meet her burden of proving by a preponderance of the evidence that she already had made "full use" of TRICARE, or other third-party resources.

The Division's denial of Claimant's proposed amendment to her plan of care requesting payment of the acuity rate add-on to her group home on this basis was correct.

VIII. The Division's Denial of the Claimant's Application Because She Receives Other Benefits Is Not Correct

As discussed above, changes to a plan of care are addressed by regulation 7 AAC 130.230(g). Subsection (3) of this regulation provides that changes to a plan of care will be approved if the department determines that "the services to be provided are not otherwise covered under 7 AAC 105 – 7 AAC 160, except as a home and community-based waiver service under 7 AAC 130.200 – 7 AAC 130.319."

Claimant's application is a proposal to change her plan of care. Therefore, the Division cannot approve her request for the acuity rate payment to provide services that already are provided to her by authority of 7 AAC 130.200 – 7 AAC 130.319.

In its denial of Claimant's application, the Division stated: "To authorize the acuity rate under 7 AAC 145.520(m), a recipient must require DEDICATED staff every hour." (Ex. D, p. 2; emphasis in original) This rationale assumes the acuity rate is paid only as a unit of 24 hours and that if Claimant does not need dedicated one-on-one staffing during any hour(s) of the day, she cannot qualify for the acuity rate at all.

The Division argued that because Claimant receives day habilitation authorized by 7 AAC 130.260, it cannot approve the acuity rate payment because there would be Medicaid payment for overlapping benefits, contrary to 7 AAC 130.230(g)(3). It is undisputed that Claimant receives day habilitation services authorized by 7 AAC 130.260. Regulation 7 AAC 130.260(b) states, in relevant part "[t]he department will consider habilitation services to be day habilitation services if they (2) do not replace, enhance, or supplement educational services for which the recipient is eligible under 4 AAC 52." *See*

footnote 19 herein. The Division makes the same argument about the hours that Claimant is at school, citing 42 C.F.R. § 441.310. The Division argued Federal regulation 42 C.F.R. § 441.310 does preclude payment for home and community-based services which overlap with special education and related services.

Claimant argues the Division's position defeats the purpose of regulation 7 AAC 145.520(m) by so narrowing the categories of potentially qualified recipients as to make the acuity rate unobtainable except for persons who do not venture into the community. Claimant argued that denying her the acuity rate because she already receives services 24 hours a day that are not one-on-one, would discriminate against her as a person who would spend time in the community, or one who might wander away from home at night if there is no awake night staff.[33] Claimant further argues that to the extent the Division's denial of the acuity rate is because Claimant receives IDEA benefits at school, the Division discriminates against her because she spends part of her day in school.[34]

The Division's rationale necessarily implies that payment of the acuity rate is limited to payment for a full 24 hours and that the acuity rate cannot be apportioned by the hour, or otherwise, to pay for the specific needs of persons who receive other Medicaid benefits. The Division's argument that the acuity rate cannot be apportioned is unreasonable, because only the home bound recipients of group-home services could be qualified recipients, in effect.

Regulation 7 AAC 145.520(m) does clearly limit the categories of persons who may be qualified recipients to persons receiving "residential supported living services under 7 AAC 130.255" or receiving "group-home habilitation services under 7 AAC 130.265." The regulation requires a "qualified recipient" to "require" dedicated one-on-one staffing 24 hours a day, but it does not restrict how that staffing is to be provided (i.e., by any one program or another) nor that the cost of staffing be paid exclusively through the acuity rate payment. Also, the regulation does not expressly state, or even imply, that the acuity rate must be paid for a "unit" of 24 hours.

Research of the Division's policy interpretation of this regulation yields scant results. The regulation became effective March 1, 2011. The Division's first Policy and Procedure Manual policy memorandum, dated February 18, 2011, was suspended by the Division policy memo dated August 5, 2011. The initial policy memorandum is silent concerning whether the acuity rate must be paid for a block of 24 hours or if payment may be apportioned by the hour. The Policy Memo of August 5, 2011 likewise is silent concerning this question. The Department of Health and Social Services has not yet promulgated a policy interpreting this regulation. At present, the department offers no policy guidance concerning conditions that are sufficient to "require" the acuity rate, nor concerning whether the acuity rate may be apportioned in "units" of less than 24 hours. *See* Principles of Law, above.

The drafters of regulation 7 AAC 145.520(m) could have limited the class of qualified recipients to only those persons who received no other benefits, but the regulation's language does not create this limit. The regulation does preclude payment of the acuity rate during times when a qualified recipient may receive other benefits, because of the operation of other Medicaid regulations prohibiting duplication of benefits. In order to give force and effect to the payment of the acuity rate as an

[33] Claimant's Initial Post-Hearing Memorandum at 10 and 13.

[34] Claimant's Responsive Post-Hearing Memorandum at 2.

additional payment, and yet adhere to Medicaid regulations, the acuity rate must be able to be apportioned in units of less than 24 hours.

Other Medicaid benefits are apportioned hourly. For example, Claimant receives day habilitation in units of hours per week. Respite care was provided to Claimant in hours per week. Thus, there is precedence in the Division's practice of apportioning Medicaid benefits to provide needed services on an hourly basis.

Claimant receives group-home habilitation services. As a recipient of group-home habilitation services authorized by 7 AAC 130.265, the "department will not pay for more than 18 hours per day of supported-living services, unless the department determines that the recipient is unable to benefit from other home and community-based waiver services…." Unlike the regulation pertaining to the other category of persons eligible for the acuity rate (those receiving residential supportive living services authorized by 7 AAC 130.255),[35] recipients of group-home habilitation services (like Claimant) are not prohibited from receiving Medicaid benefits while receiving benefits from other sources. For example, if Claimant proved she qualified for payment of the acuity rate for the night time hours, she could have received the acuity rate of payment during the night hours she required the dedicated one-on-one staff.

Therefore, the Division's argument that Claimant's request for payment of the acuity rate add-on should be denied because it is a 24 hour unit payment that would impermissibly overlap with other Medicaid benefits is not persuasive. The Division was incorrect to deny Claimant's application for this reason.

CONCLUSIONS OF LAW

1. Claimant failed to meet her burden of proving by a preponderance of the evidence that:

   a. She is qualified to receive the acuity rate of payment. Claimant's plan of care did not document she requires a dedicated one-on-one staff 24 hours per day, and therefore she is not a recipient qualified for the add-on payment. 7 AAC 145.520(m).

   b. She has fully used all third-party resources before seeking Medicaid payment of the acuity rate, including services and benefits through TRICARE. 7 AAC 160.200.

2. The Division incorrectly denied Claimant's proposed amendment to her plan of care requesting 72 units of acuity rate add-on payment to her group home on grounds that payment could not be apportioned to units less than 24 hours each.

3. The Division correctly denied Claimant's proposed amendment to her plan of care because Claimant did not prove she was a "qualified recipient" requiring the acuity rate payment, and because Claimant did not fully use third-party resources before seeking the additional Medicaid acuity rate payment.

[35] Regulation 7 AAC 130.255(c)(2)(C) states the "department will not pay [for] activities or supervision for which a source other than Medicaid makes payment…."

DECISION

On August 15, 2011, the Division was correct to deny Claimant's proposed amendment to her plan of care requesting 72 units of acuity rate add-on payment to her group home.

APPEAL RIGHTS

If for any reason Claimant is not satisfied with this decision, Claimant has the right to appeal by requesting a review by the Director. 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. To appeal, Claimant must 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

DATED January 17, 2012.

/signed/
Claire Steffens
Hearing Authority

CERTIFICATE OF SERVICE

I certify that on January 17, 2012 true and correct copies of the foregoing were sent to:

Claimant, via her legal representative, Disability Law Center, c/o Mr. Mark Regan by certified mail, return receipt requested, */signed/* CS/Hearing Authority

and on January 18, 2012 via secure, encrypted e-mail, to Claimant and others as follows:

Division of Senior and Disabilities Services, via Kimberly Allen, Asst. Attorney General
[redacted], Hearing Representative
[redacted], Director, DSDS
[redacted], Chief, Policy & Program Dev.
[redacted], Eligibility Technician
[redacted], Staff Development & Training

/signed/
J. Albert Levitre, Jr.
Law Office Assistant I