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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-2501
	)	
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) Adults with Physical Disabilities (APD) program. (Ex. A, p. 2) Claimant submitted a proposed amendment to her existing plan of care on September 19, 2011. (Ex. A, p. 2) Included in Claimant's proposed amendment was a request that Medicaid pay her group-home an acuity rate supplemental payment for 365 days. (Ex. E, p. 11) On November 29, 2011, the Division of Senior and Disabilities Services (SDS) notified Claimant it had denied her request for "366 units" of "Acuity Add-On" benefits.[1] (Ex. D, p. 1)

On December 30, 2011, Claimant requested a Fair Hearing. (Ex. C) This office has jurisdiction pursuant to 42 C.F.R. §§ 431.200-431.250 and 7 AAC 49.010-.020.[2]

A Fair Hearing was scheduled for March 6, 2012 and began as scheduled. Claimant participated by telephone, represented herself and testified in her behalf. Claimant was assisted by her mother, Ms. [redacted], and by members of the [redacted] Services agency as follows: Mr. [redacted], Executive Director; Ms. [redacted], Waiver Manager, and Ms. [redacted], Team Leader and Support Staff, and Ms. [redacted], Claimant's Care Coordinator. Each of these persons participated telephonically on behalf of Claimant.

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[1] It is unclear why the Division's denial was for one day more than Claimant requested. For purpose of this decision, 366 units/days has been selected.

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

The Alaska Division of Senior and Disabilities Services (Division) was represented by Ms. [redacted], the Division's Hearing Representative. She testified on behalf of the Division. In addition, Ms. [redacted], a Health Program Manager with the Division, testified on behalf of the Division.

The evidentiary record was closed at the end of the hearing and all offered exhibits were admitted into evidence.

ISSUE

On November 29, 2011, was the Division correct to deny the portion of Claimant's proposed amendment to her existing plan of care that requested a supplemental Medicaid acuity rate payment to her group-home for 366 units (366 days)?

FINDINGS OF FACT

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

A. Background

1. Claimant, 27 years old, has Transverse Mylitis, which has made her a C-4 quadriplegic. (Ex. E, p. 8) A secondary diagnosis is "neurogenic bladder." (Ex. E, p. 5) Claimant takes medications to regulate bladder and bowel functions and for muscular spasms. (Ex. E, p. 8) Claimant cannot be left alone because spasticity may affect her lungs. (Claimant's testimony) Claimant is articulate, has full capability of her mental faculties, is competent in scheduling her activities, and enjoys "living in her own space." (Ex. E, p. 8) Claimant has an immediate family consisting of two young sons and their father, her mother, and friends who provide support for her. (Ex. E, pp. 8, 16) Claimant's goals are to parent her children and complete her college education. (Ex. E, p. 8)

2. The parties stipulated that Claimant is completely dependent on others for her care and requires one-on-one care, twenty-four hours a day, seven days a week. It is undisputed that Claimant lives in a group-home at which she is the sole resident, and has received one on one care, twenty-four hours, seven days a week. (Ex. E, p. 14; Ex. F, pp. 1-21)

3. It is undisputed Claimant receives Medicaid paid services through an existing Adult Public Assistance (APA) Home and Community-Based Services Waiver program (HCBW) Adult with Physical Disabilities (APD) Plan of Care.[3] (Ex. D) In September 2011, Claimant's Plan of Care (starting July 27, 2011 and ending July 26, 2012) included the following services: (Ex. E, p. 1)

   a. Care Coordination through [redacted] Services including two contacts per month. (Ex. E, p. 9)

[3] Claimant has had approved Plans of Care effective between September 15, 2009 and July 28, 2011. (Ex. F, pp. 53-66; Ex. G, pp. 2-14).

b. Residential habilitation services in the form of group-home services, coded T2016, 7 days per week, 365 days a year. (Ex. E, pp. 1, 10)[4] These include 8 hour shifts with 24 hour staffing. (Ex. E, pp. 14-15)

c. Day habilitation services of an average of 12 hours (48 units) per week for a total of 624 hours, (2496 units) per waiver year. (Ex. E, p. 13)

d. Intensive Active Treatment, 18 weeks, and Nursing Oversight and Case Management 14 units weekly for 34 additional weeks, (478 units).[5] (Ex. E, pp. 1, 14; *See* Ex. G, pp. 58-63)

4. On or about September 6-19, 2011, Claimant submitted a proposed amendment to her existing Plan of Care. (Ex. E, Ex. E, p. 19) The Division of Senior and Disabilities Services date stamped the submission on September 19, 2011. (Ex. E, p. 2)

5. On November 29, 2011, the Division of Senior and Disabilities Services (Division) notified Claimant by letter of its decisions concerning her proposed amendment. (Ex. D) The notifying letter informed Claimant "the following services will be approved as requested: 1) Group Home, 366 Units; 2) Intensive Active Treatment, 2 Units; 3) Nursing Oversight and Case Management < 200, 478 Units." (Ex. D, p. 1; Ex. E, pp. 4-19)

6. In her proposed amendment to her Plan of Care, Claimant also requested Medicaid pay an additional benefit, called an "Acuity Add-On," 7 days a week for 365 units (365 days). (Ex. E, pp. 11)

7. However, also on November 29, 2011, the Division denied Claimant's request for "Acuity Add-On: 366 units (366 days)". (Ex. D)

8. The Division explained its denial of the Acuity Add-On payment based on three factors. (Ex. D, p. 2)

a) Claimant's needs do not require a one-on-one staff person dedicated exclusively to Claimant, 24 hours a day. (Ex. D, p. 2; Reviewer's testimony)

b) Claimant's needs for one-on-one staff, 24 hours a day, already are addressed by the services she receives through Nursing Oversight and Care Management,[6] Day Habilitation and Group-home services. (Ex. D; Reviewer's testimony)

c) Claimant is not at risk of institutionalization if she does not receive the Acuity Add-On rate. (Ex. D; Reviewer's testimony)

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[4] It is undisputed Claimant receives group-home habilitation services as residential habilitation services authorized by 7 AAC 130.265(b)(4) and assigned procedure code T2016 in the Healthcare Common Procedure Coding System.

[5] The Division's letter dated November 29, 2011 does not address Claimant's request for 624 hours of day habilitation, these are not at issue in this case, and therefore are not addressed.

[6] The terms Nursing Oversight and Care Management describe the same services provided by Intensive Active Treatment. The Intensive Active Treatment (IAT) terminology is being phased out due to changes concerning payment for IAT. (Reviewer's testimony)

9. Claimant believes that she is entitled to receive the supplemental acuity payment because she understands the regulation provides the acuity payment to everyone who receives one-on-one care, 24 hours a day, 7 days a week. (Claimant's testimony; Executive Director of [redacted]S' testimony) Claimant agrees she is not at risk of having to live in an institution if she does not receive the acuity payment. (Claimant's testimony) If Claimant were provided the acuity supplement, she would not receive additional staff to care for her and the existing staff would not necessarily receive any portion of the supplemental acuity payment. (Claimant's testimony; Executive Director of [redacted]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 Home and Community-Based Services Program

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.

The federal Medicaid program allows states to choose to provide Medicaid benefits to its qualifying needy citizens under a program called "Home and Community-Based Services (HCBW)." The HCBW program is called a "waiver" program because federal law waives some statutory Medicaid eligibility requirements to allow states to provide Medicaid benefits to individuals whose needs can be met by "an array of home and community-based services." 42 C.F.R. § 441.300. The purpose of the waiver of statutory requirements is to provide an array of home and community-based services that an individual needs so the individual can avoid institutionalization. (*Id.*, 42 C.F.R. § 441.302(g)).

Some federal Medicaid regulations concerning the home and community-based services program (HCBW) are found at 42 C.F.R. §§ 441.300-310 and 42 C.F.R. § 440.180. The HCBW program is available only to recipients who would require "the Medicaid covered level of care provided in" a hospital, a nursing facility (NF) or an intermediate care facility for the mentally retarded (ICF/MR).[7] 42 C.F.R. § 441.301(b)(1)(iii). The state providing a HCBW program must assure the federal Centers for Medicaid and Medicare Services (CMS) that the cost of providing the HCBW program does not exceed 100 percent of the Medicaid cost had the recipients of state HCBW benefits been institutionalized, instead of receiving care through the HCBW program. (42 C.F.R. § 441.302(f).

Regulation 42 C.F.R. § 440.180 states, in relevant part:

[7] The recipient must require hospital services as described in 42 C.F.R. § 440.10 or nursing facility services as per 42 C.F.R. § 440.40.

> (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.

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….") Alaska statute 47.07.45 establishes the Alaska Home and Community-Based Services Program (HCBW) under a waiver of Medicaid requirements in accord with 42 U.S.C. 1396-1396p.

Applicable regulations for the Alaska Home and Community-Based Services Medicaid waiver (HCBW or Waiver) program are found in the Alaska Administrative Code (AAC) at Title 7, Chapters 100 – 160. "[H]ome and Community-Based Waiver services" is defined to mean services provided under AS 47.07.045 and 7 AAC 130. 7 AAC 160.990(26).

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

The purpose of Home and Community-Based Services program (HCBW or 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. Home and community-based waiver services are paid according to 7 AAC 145.520. Payments are made for services including care coordination, specialized medical equipment and supplies, specialized private duty nursing services, environmental modification services, chore services, adult day and day habilitation services, supported-employment services, intensive active treatment services, respite care services, transportation services, meals services, personal care attendant services, residential supported-living services and group-home habilitation services. 7 AAC 145.520(b)-(m).

Regulation 7 AAC 130.260 provides for payment for day habilitation services for adults with physical disabilities. Day habilitation services are characterized as services that

> (1) take place in a nonresidential setting, separate from the home, …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 ….

Regulation 7 AAC 130.265 provides for payment for residential habilitation services to adults with physical disabilities. Residential habilitation services may be characterized as group-home habilitation services if they are provided to a recipient 18 years of age or older living full time in a licensed assisted living home.

In November 2011, regulation 7 AAC 145.520(m) provided that if a recipient of HCBW was receiving either residential supported-living services (procedure code T2031) or group-home habilitation

services (procedure code T2016),[8] the recipient might qualify for an additional payment of Medicaid benefits.[9] The payment was "$320 per approved day in addition to the qualified recipient's daily rate" for the other services authorized in the recipient's plan of care.[10] 7 AAC 145.520(m). To receive the supplemental acuity payment, the individual must be a "qualified recipient [who] 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."[11]

ANALYSIS

I. Issue

On November 29, 2011, was the Division correct to deny the portion of Claimant's proposed amendment to her existing plan of care that requested a supplemental Medicaid acuity rate payment to her group-home for 366 units (366 days)?

Claimant applied to amend her existing plan of care to obtain additional Medicaid benefits in the form of the supplemental acuity Medicaid payment. Therefore, Claimant is seeking 1) to change the status quo and 2) to be eligible as a qualified recipient to obtain more Medicaid 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)

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[8] Group-home habilitation services under 7 AAC 130.265(h)(4) require the recipient to be 18 years of age or older and living full time in a state licensed assisted living home. This case pertains to a physically disabled adult who receives group-home habilitation services under 7 AAC 130.265(h)(4) that are assigned procedure code T2016.

[9] This additional payment is sometimes called an "acuity add-on."

[10] Effective April 1, 2012, this regulation was changed to provide that the supplemental payment is made as "an acuity rate at the daily rate established in the departments' *Chart of Personal Care and Waiver Services Rates*." The change in the regulation does not affect this case or the decision.

[11] On April 1, 2012, regulation 7 AAC 130.267 titled "Acuity payments for qualified recipients" became effective. Although the adoption of 7 AAC 130.267 does not affect this case or decision, it is instructive because it refines the regulatory intent of 7 AAC 145.520(m) concerning who is a qualified recipient and what is the purpose of providing the acuity payment. Regulation 7 AAC 130.267 subsection (a) provides the department will approve an acuity payment for additional services for a recipient who is eligible for and receiving either residential supported-living services or group-home habilitation services and is a "qualified recipient" under subsection (b) of 7 AAC 130.267. Subsection (b) states a qualified recipient is one who: "(1) needs services that exceed what is currently authorized in the recipient's current plan of care under 7 AAC 130.230; and (2) because of the recipient's physical condition or behavior, needs direct one-on-one support from workers whose time is dedicated solely to providing services under (a)(1)(A) of this section to that one recipient 24 hours per day, seven days per week, in all environments in which the recipient functions."

Claimant must prove by a preponderance of the evidence that she qualifies for the supplemental acuity payment. 7 AAC 145.520(m).

II. Claimant did not prove she is a recipient qualified to receive the supplemental acuity payment.

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 therefore that Claimant falls within the categories of Medicaid recipients potentially eligible for the acuity rate authorized by 7 AAC 145.520(m).

The undisputed facts in this case include that Claimant is the sole occupant of a group home and has her needs met 24 hours a day, 7 days a week by a caregiver, as authorized under her existing plan of care. It is undisputed that Claimant receives residential habilitation services 24 hours a day, 7 days a week as a member of her group-home and, in addition, when she is away from home, Claimant continues to receive one-on-one care through day habilitation services. All these services are authorized in her existing plan of care.

Claimant's evidence, including her testimony, is that her needs are adequately met, that she receives good care and is not in jeopardy of being institutionalized if she does not receive the supplementary acuity rate of payment.

The Division asserts Claimant's needs are already met in a manner sufficient to keep her from becoming institutionalized by the services provided in her existing plan of care. Therefore, Claimant does not need additional staff to be dedicated exclusively to her and hence does not need the supplemental acuity payment.

Claimant requested the supplemental acuity payment because she interprets the applicable regulations as necessarily providing her the acuity payment because she receives one-on-one care, 24 hours a day, seven days a week. Claimant's reason for requesting the acuity rate of payment is not because she has unmet needs that only a dedicated caregiver can give her. The fact that Claimant is the sole occupant of her group home means that her existing plan of care provides her, in effect, with dedicated one-on-one staff, already fully paid by Medicaid. Claimant, through her witnesses, testified that if she received the acuity rate of payment, she would not receive additional staff to care for her, nor would existing staff necessarily receive the payment for additional work or increased wages.

The supplemental acuity payment is an additional payment to ensure a recipient who needs one-on-one care dedicated exclusively to that recipient does receive such dedicated care. Here, it is undisputed Claimant does not need additional services to ensure her needs are met and it is undisputed that the services she presently receives are adequate to keep her from being institutionalized.

Claimant has failed to prove by a preponderance of the evidence that she needs the supplemental acuity payment to provide her with staff dedicated solely to meeting her needs, one-on-one, 24 hours a day, 7 days a week.

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. 7 AAC 145.520(m).

b. She will become institutionalized if she does not receive the acuity rate of payment. 42 C.F.R. § 441.302(g); 7 AAC 130.200.

DECISION

On November 29, 2011, the Division was correct to deny Claimant's proposed amendment to her plan of care requesting 366 units (366 days) 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 Senior and Disabilities Service
550 West 8th Avenue
Anchorage, AK 99501

DATED April 26, 2012.

/signed
Claire Steffens
Hearing Authority

CERTIFICATE OF SERVICE

I certify that on April 26, 2012 true and correct copies of the foregoing were sent to:
Claimant, USPS return receipt requested
/signed/
and by secure, encrypted email on April 27, 2012 to:
[redacted], Hearing Representative, Medical Assistance Analyst
[redacted], Director, DSDS
[redacted], Staff Development & Training
[redacted], Eligibility Technician
[redacted], Chief, Policy & Program Dev

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