BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS
ON REFERRAL BY THE COMMISSIONER OF HEALTH AND SOCIAL SERVICES

In the Matter of	)	
	)	
L C	)	OAH No. 12-0616-MDS
	)	Former OHA No.
	)	Medicaid ID No.

DECISION

I. Introduction

The issue in this case is whether L C is entitled to receive an Acuity Add-On payment rate pursuant to 7 AAC 145.520(m) and 7 AAC 130.230(f). This decision concludes that Ms. C does not require "dedicated one-on-one staffing 24 hours per day" in order to avoid institutionalization. The Division of Senior and Disabilities Services (DSDS or Division) was therefore correct when it denied that portion of Ms. C' proposed renewal Plan of Care which requested the Acuity Add-on rate, and its decision is therefore affirmed.

II. Facts

A. Ms. C' Medical Condition and Impairments

Ms. C is a 61 year old woman who has lived at the D J X H Home since 1997.[1] Her diagnoses include left-sided hemiparesis, mental retardation, seizure disorder, static encephalopathy, and urinary incontinence.[2] Although she takes anti-seizure medication she occasionally has breakthrough seizures lasting up to three minutes.[3] She is able to make only very simple decisions; all decisions regarding her health care, living arrangements, and money matters are made by her sister / guardian.[4] She cannot speak and expresses herself through eye contact, laughing, crying, moaning, and yelling.[5] She is wheelchair-bound and unable to operate the chair herself; her caregivers must do so for her.[6] Ms. C must be lifted by her caregivers to transfer from her wheelchair to her bed, bath chair, or the toilet; this often requires a two person

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1 Ex. E7.
2 Ex. F23.
3 Ex. F6.
4 Ex. E6.
5 Exs. E6, F24.
6 Ex. F23.

assist.[7] She is dependent on her caregivers for all of her activities of daily living including eating, dressing, toileting, personal hygiene, and bathing.[8]

Ms. C will refuse to eat, drink, or take her medications when there are people around with whom she is not comfortable.[9] She has difficulty swallowing and can only consume liquids that have been thickened to the consistency of pudding.[10] She is at high risk for aspiration and so must be monitored while eating.[11] Because she is incontinent and wheelchair-bound, she is at high risk for urinary tract infections, and because of her immobility she also has problems with constipation.[12] Because she cannot communicate effectively, caregivers must give her numerous opportunities to use the toilet.[13] Also, because she cannot reposition herself, Ms. C is at risk for skin infections and skin breakdown.[14] Staff performs physical therapy daily to maintain her range of motion.[15]

Ms. C has a high visible pain threshold; this became apparent when it was found she had been suffering from gallstones for some time before the gallstones were discovered and removed.[16] As a result of this, and her inability to speak, her caregivers must be very attentive to discover emerging health problems early on.[17]

During the period from May through August 2011, seven medications were being administered daily to Ms. C. These were acetaminophen suppositories (every six hours), aloe cream (applied at each diaper change), Benadryl (every six hours), Sudafed (every four hours), Tylenol (every four hours), Levetiracetam (twice a day), Lisinopril (one a day), Neurontin (three times a day), Nystatin creme (as needed), Tegretol (twice a day), and Topomax (twice a day).[18] Additional medications are administered when Ms. C is constipated.[19]

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7 Exs. F23 - F24.
8 Ex. F23.
9 Ex. H4.
10 Ex. F24.
11 Ex. F24.
12 Ex. F24.
13 Ex. F24.
14 Ex. F24.
15 Ex. F7.
16 Ex. E8.
17 Ex. E8.
18 Exs. E5, F20, H14, H15, H16, H19.
19 *Id.*

Care logs for the month of August 2011 indicate that Ms. C typically sleeps well at night, but awakens (or is awakened by staff) on an average of twice per night to use the bathroom or have her diaper changed.[20]

Ms. C' medical condition and need for services has remained fairly stable from April 2009 through the January 2012 hearings in this case.[21]

B. The D J X H Home

The D J X H Home is an assisted living facility located in east No Name and is operated by the B of B ("the B").[22] The home is state-certified for up to four residents.[23] As of June 2011 there were three residents living at the D J X H Home, one of these being Ms. C.[24] Each of these residents has been characterized by Terry Rosso of DSDS as "medically fragile," requiring "total care with all [activities of daily living]."[25]

In 2009 the B filed an administrative proceeding with the Office of Rate Review (ORR) of the Department of Health and Social Services (DHSS) to obtain an increased daily payment rate for the care of its D J X H Home residents.[26] At that time, the applicable base rate was $209.51 per day,[27] and there was no acuity add-on rate available for *recipients* through DSDS. However, there was an increased rate available for *facilities* (like the B) known as the Health and Safety Rate (HSW).[28] In January 2010 the B and ORR/DHSS signed a settlement agreement to resolve the issue.[29] Pursuant to the settlement, the B received an increased HSW rate for its care of Ms. C and the other two D J residents.[30] This increased HSW rate of $418.09 per day was to remain in effect "[u]ntil new regulations are adopted and effective that affect the manner in

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20 Exs. I2 - I34.

21 Ms. B testified at hearing that Ms. C' staffing needs have remained fairly constant, although she did not specify a particular time frame. This is consistent with the information reported in Ms. C' last three Plans of Care. *Compare* Ms. C' Plan of Care for the period April 1, 2009 through March 31, 2010 (Exs. 2-4 through 2-18), with Ms. C' Plan of Care for the period April 2, 2010 through April 1, 2011 (Exs. 1-5 through 1-21), and with Ms. C' proposed Plan of Care for the period April 2, 2011 through March 20, 2012 (Exs. E-3 through E-17).

22 Ex. K2.

23 Ex. K3.

24 Exs. K2, K3.

25 Ex. K3.

26 *In the Matter of the B of B*, Case No. 2009-OHA-11. *See* Ex. 3.

27 Ex. 2-46. Prior to March 2011 the applicable rates were basically set by historical evolution (Jack Nielsen hearing testimony). However, since amended regulations took effect in March 2011, the rates have been set by statistical sampling and averaging. *Id.*

28 Jack Nielsen hearing testimony.

29 Ex. 3.

30 Ex. 3-2.

which daily rates are set for the type of service currently provided to [the three D J residents]."[31] That new regulation, an amendment to 7 AAC 145.520, became effective on March 1, 2011.[32]

During May - June 2011 the D J X H Home had three staff on duty during the hours of 7:00 a.m. - 11:00 p.m., providing 1-on-1 daytime care for each resident.[33] There are two staff on duty from 11:00 p.m. - 7:00 a.m.; one of the overnight staff stays awake all night to monitor and assist the residents, while the other staff member sleeps but is still on-call.[34] Eleven different staff members typically provide care for the residents during any given week.[35] Care is available 24 hours a day, seven days a week.[36]

C. Relevant Procedural History

Ms. C has received Medicaid Home and Community-Based Waiver Services through the Waiver Services Program for persons with Intellectual and Developmental Disabilities ("IDD") since at least 2008.[37] On May 26, 2011 Ms. C' Care Coordinator, E B, submitted a written request to DSDS for the acuity add-on.[38] Ms. B asserted that:

1. The current base rate for the D J home did not provide for the "medical concerns" presented by Ms. C.[39]

2. Ms. C had previously received a level of care, equivalent to that which would be provided by an acuity add-on, under the Office of Rate Review's former "Health and Safety" rate.[40]

3. Without the services provided under an acuity add-on, Ms. C would most likely have to be moved to a long term care facility (*i.e.* be institutionalized).[41]

On May 31, 2011 Ms. C submitted a proposed renewal Plan of Care (POC) to the Division covering the period April 2, 2011 through March 20, 2012.[42] The specific waiver services requested by Ms. C in her proposed Plan of Care, (other than the acuity add-on

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31 Ex. 3-2.
32 Alaska Administrative Code, Register 197.
33 Exs. F25, K3.
34 Exs. F25, J2 - J4, K3.
35 Ex. F25.
36 Exs. F16, F18.
37 Exs. E3, 2-30, and 3. The Intellectual and Developmental Disabilities (or IDD) Waiver was previously known as the waiver for the Mentally Retarded and Developmentally Disabled (MRDD).
38 Ex. F23.
39 Ex. F23.
40 Ex. F23.
41 Ex. F23.
42 Ex. E2.

referenced above), were Care Coordination Services, Residential Habilitation Services (group home), and Nursing Oversight.[43]

On August 17, 2011 the Division approved the proposed POC in part and denied in part.[44] The portion of the proposed POC that was denied by the Division was 354 units (354 days) of the Acuity Add-On payment rate.[45] The Division's August 17, 2011 notice stated in relevant part:[46]

> The Division denies the [acuity add-on] under the authority of 7 AAC 130.230, 7 AAC 130.265, 7 AAC 145.520, and 7 AAC 130.260 . . . .
>
> There is not sufficient justification that [Ms. C] requires assigned one-to-one staffing dedicated to her care 24 hours per day, in addition to 24 hours per day, 7 days per week Residential Group Home service.
>
> [Ms. C] is authorized for Residential Habilitation Group Home service which provides staffing 24 hours per day, 7 days per week for her care . . . .
>
> Please keep in mind that all residential habilitation recipients demonstrate the need for assistance on a 24 hour basis; the residential group homes already receive a base rate for that service. Dedicated one-to-one staff is a much higher level of care. [Ms. C] is eligible for and currently receives Residential Habilitation Group Home service which provides staffing 24 hours per day, 7 days per week for her care . . . .
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> [Ms. C] has been authorized for Day Habilitation service for the past three years. However, this service was not requested in the renewal POC. Day Habilitation service can be requested by amendment to provide an augmented level of dedicated one-to-one staffing . . . . [Ms. C] has successfully used Day Habilitation service [in the past] . . . .
>
> The requested Group Home Acuity add-on, of 354 units (354 days) is denied because Residential Habilitation Group Home service in addition to [available] Day Habilitation service is of sufficient amount, duration, and scope to prevent institutionalization . . . .

Ms. C' care coordinator requested a hearing on Ms. C' behalf on August 19, 2011.[47]

Ms. C' hearing began on January 9, 2012. Ms. C was represented by Mark Regan of the Disability Law Center of Alaska. Ms. C' Care Coordinator E B, her PCA X J, her sister and legal

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43 Exs. E9 - E13.
44 Exs. D1 – D3.
45 Ex. D1.
46 Exs. D1, D2.
47 Ex. C.

guardian L C, and her brother T C attended the hearing and testified on Ms. C' behalf. The Division was represented by Kimberly Allen. Theresa Rosso, a Health Program Manager I for DSDS, attended the hearing and testified on behalf of the Division. The Office of Rate Review was represented by Linda Kesterson. Jack Nielson, the Executive Director of the Office of Rate Review, attended the hearing and testified on behalf of ORR.

The hearing could not be completed on January 9, 2012 and so supplemental hearings were held on January 20 and January 24, 2012.[48] Post-hearing briefing was completed, and the record closed, on March 5, 2012.

III. Discussion

A. Medicaid Home and Community-Based Waiver Services Program - Overview

1. Relevant Federal Medicaid Statutes and Regulations

The Medicaid program has a number of coverage categories. One of those coverage categories is the Home and Community-Based Waiver Services program[49] ("Waiver Services"). Congress created the Waiver Services program in 1981 to allow states to offer long-term care, not otherwise available through the states' Medicaid programs, to serve eligible individuals in their own homes and communities instead of in nursing facilities.[50]

To obtain approval from the federal Center for Medicare & Medicaid Services ("CMS") for a home and community-based care waiver, the state seeking the waiver must demonstrate that its average per capita expenditures for persons receiving benefits under the waiver do not exceed the average estimated per capita cost of providing Medicaid services to the same group of

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[48] Jan Bragwell, a registered nurse employed by DSDS, testified by telephone at hearing on January 24, 2012.

[49] The program is called a "waiver" program because certain statutory Medicaid requirements are waived by the Secretary of Health and Human Services. *See* 42 U.S.C. § 1396n(c). Before a state receives federal funding for the program, the state must sign a waiver agreement with the United States Department of Health and Human Services. *Id.* The agreement waives certain eligibility and income requirements. *Id*.

[50] *See* 42 U.S.C. § 1396n(c)(1); 42 C.F.R. §§ 435.217; 42 C.F.R. §§441.300 - 310. Federal Medicaid regulation 42 C.F.R. § 440.180, titled "Home or Community-Based Services," provides in relevant part:

> (a) Description and requirements for services. "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 . . . .
>
> (b) Included services. Home or community-based services may include the following services . . . (1) Case management services. (2) Homemaker services. (3) Home health aide services. (4) Personal care services. (5) Adult day health services. (6) Habilitation services. (7) Respite care services. (8) Day treatment . . . (9) Other services requested by the agency and approved by CMS *as cost effective and necessary to avoid institutionalization*. [Emphasis added].

individuals in an institutional setting.[51] Any failure to abide by this requirement will result in CMS' termination of the state's Waiver Services program.[52]

The impact of the Waiver Services program's cost-neutrality provision is that waiver services are not required to provide the best possible treatment and services to its recipients. Rather, the Waiver Services program is only required to provide recipients with those services, costing no more than institutional care, which are necessary to avoid institutionalization.[53]

2. Relevant State Medicaid Statutes and Regulations

Alaska participates in the Medicaid Waiver Services program.[54] Alaska's Waiver Services program pays for specified individual services for Waiver Services recipients.[55] The Division must approve each specific service as part of a Waiver Services recipient's Plan of Care (POC).[56] Services must be "of sufficient amount, duration, and scope to prevent institutionalization."[57] A Waiver Services recipient's plan of care is subject to review on an annual basis.[58]

Under 7 AAC 145.520(m), a Waiver Services recipient who receives Group Home Habilitation Services (residential habilitation services)[59] may be found eligible to receive an acuity add-on rate, which is paid to the recipient's provider:

> A qualified recipient receiving residential supported-living services under 7 AAC 130.255 . . . or group-home habilitation services under 7 AAC 130.265 . . . is eligible for an acuity 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

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51 *See* 42 U.S.C. § 1396n(c)(2)(D).

52 See 42 U.S.C. § 1396n(f)(1).

53 *See also Alexander v. Choate*, 469 U.S. 287, 303, 105 S.Ct. 712, 83 L.Ed.2d 661 (1985) (Medicaid only assures that individuals will receive "adequate health care," not care tailored to their needs).

54 AS 47.07.045, the Alaska statute that authorizes Medicaid Waiver Services, states in relevant part: Home and community-based services. (a) The department may provide home and community-based services under a waiver in accordance with 42 U.S.C. 1396 – 1396p (Title XIX Social Security Act), this chapter, and regulations adopted under this chapter, if the department has received approval from the federal government and the department has appropriations allocated for the purpose. To supplement the standards in (b) of this section, the department shall establish in regulation additional standards for eligibility and payment for the services.

55 7 AAC 130.230(c).

56 7 AAC 130.230(f).

57 7 AAC 130.230(f)(1).

58 7 AAC 130.230(g).

59 *See* 7 AAC 130.265.

and approved under 7 AAC 130.230 documents and *requires that the recipient receive dedicated one-on-one staffing 24 hours per day*.[60]

Alaska's Waiver Services regulations do not define the term "dedicated one-on-one staffing."

B. The Issues Raised by the Parties

The parties have raised three basic issues in this case. Those issues are:

1. Did the Division's notice of action dated August 17, 2011 (Ex. D) provide sufficient notice of the reason(s) why the Division denied Ms. C' request for the acuity add-on?

2. Which party bears the burden of proof in this case?

3. Does Ms. C require dedicated one-on-one staffing 24 hours per day, as provided by the acuity add-on, in order to avoid institutionalization?

These three issues are addressed below in the order stated.

C. The Division's Notice of Action Dated August 17, 2011 was Adequate

Ms. C asserts that the Division's notice of action dated August 17, 2011 (Ex. D) was not legally adequate.[61] Assessment of this argument requires a review of the applicable state and federal regulations concerning required notice of adverse action.

Federal Medicaid regulation 42 C.F.R. § 431.210(a) requires in relevant part that notices issued in the administration of the federal Medicaid program which involve the suspension, reduction, or termination of benefits provide (1) a statement of what action the department intends to take; (2) the reasons for the action; and (3) the specific regulation that supports the action. Similarly, DHSS Fair Hearings regulation 7 AAC § 49.070 provides in relevant part that "unless otherwise specified in applicable federal regulations, written notice to the client must detail the reasons for the proposed adverse action, including the statute, regulation, or policy upon which that action is based."

Initially, it is arguable that 42 C.F.R. § 431.210(a) does not apply here due to the fact that, although Ms. C previously received the old HSW rate, the acuity add-on is a new waiver

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[60] 7 AAC 145.520(m) (pre-April 2012 version – emphasis added). This regulation was amended effective April 1, 2012. (Register 201). However, the version of the regulation which applies to this case is the version that was in effect on May 31, 2011 when Ms. C' proposed POC amendment, containing her request for the acuity add-on rate, was submitted to the Division. *See Lewis v. Grinker*, 1987 WL 8412 (E.D.N.Y. 1987); *Pack v. Osborn*, 881 N.E.2d 237 (Ohio 2008); *Dambach v. Department of Social Services, Family Support Division*, 313 S.W.3d 188 (Mo. App. E.D. 2010). Accordingly, the version of the regulation relevant here (quoted above) is the version of 7 AAC 145.520(m) that was in effect from March 1, 2011 through March 31, 2012.

[61] *See* Ms. C' Initial Post-Hearing Brief at pp. 7-11; Ms. C' Post-Hearing Reply Brief at pp. 3-5.

service which she has not previously received. Accordingly, it is at least arguable that the Division's denial of the acuity add-on does not constitute the "suspension, reduction, or termination of benefits." However, 7 AAC § 49.070 applies to *any* adverse action, including the denial at issue here. Accordingly, it is clear that, pursuant to 7 AAC § 49.070, the Division was required to advise Ms. C of (1) the reason for its denial of her acuity add-on request; and (2) the statute, regulation, or policy supporting the denial.

The basis for the Division's denial of the acuity add-on request, as ultimately stated at hearing and in its pre- and post-hearing briefing, is that Ms. C does not require "dedicated one-on-one staffing 24 hours per day" in order to avoid institutionalization. The Division's notice of action dated August 17, 2011 (Ex. D) communicated this adequately: "[t]here is not sufficient justification that [Ms. C] requires assigned one-to-one staffing dedicated to her care 24 hours per day," and because "Residential Habilitation Group Home service in addition to [available] Day Habilitation service is of sufficient amount, duration, and scope to prevent institutionalization."[62] The Division's notice also cited to 7 AAC 145.520 (the regulation providing the acuity add-on), and 7 AAC 130.230 (the regulation requiring that services be of sufficient amount, duration, and scope to prevent institutionalization),

The purpose of notice is (1) to give the claimant an adequate basis on which to decide whether to appeal; and (2) to help the claimant know what issues to address at the hearing. The first purpose was adequately served, since Ms. C did in fact decide to appeal. The second purpose was also adequately served, in that Ms. C had extensive information about the reasons for the denial well before the hearing concluded. Her counsel did not request additional time, beyond the third session of the hearing, to develop the case further in response to the testimony of the Division's witnesses.

In conclusion, notice need not be perfect in order to be legally sufficient.[63] The Division's notice in this case complied with 7 AAC § 49.070, which required the Division to state (1) the reason for its denial of the acuity add-on request; and (2) the statute, regulation, or policy supporting the denial. Accordingly, the notice provided by the Division was adequate.

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[62] Ex. D at pp. 1, 2.

[63] *See Fairbanks North Star Borough v. College Utilities Corp*., 689 P.2d 460, 463 (Alaska 1984); *Marshall v. Provision House Workers Union, Local 274*, 623 F.2d 1322, 1325 (9th Cir.1980).

D. The Burden of Proof is Properly Placed on the Division in This Case

The Division asserts that the burden of proof was improperly placed on it at hearing.[64] It argues that, because the acuity add-on is a newly available waiver service, which Ms. C has never had under any prior Plan of Care, Ms. C must be viewed as seeking additional services by X of her POC amendment. This being the case, Ms. C would bear the burden of proof because she would be the party attempting to change the status quo.[65]

Due to the requirements of 42 C.F.R. § 435.930,[66] Medicaid eligibility, once established, continues until such time as a change in circumstances is demonstrated by the Division.[67] The evidence in this case indicates that Ms. C' medical condition and needs have remained fairly stable during the period 2009 - 2012.[68]

The Division further asserts, however, that the fact that Ms. C seeks an elevated level of funding under a *new regulatory scheme* makes it unnecessary for it to demonstrate the change in circumstances otherwise required by federal Medicaid regulations. In other words (the Division asserts), the fact that Ms. C *previously enjoyed* an augmented level of funding under the old HSW rate, and now seeks to *continue receiving* an augmented level of funding under the new acuity add-on, is legally irrelevant.

Essentially the same argument asserted here by the Division was addressed by the court in *Balino v. Department of Health and Rehabilitative Services*, 348 So.2d 349, 350-351 (Fla.

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64 *See* the Division's Initial Post-Hearing Brief at pages 3-5.

65 The general rule regarding the allocation of the burden of proof in administrative proceedings is simple: the party seeking a change in the status quo or existing state of affairs generally bears the burden of proof. *State of Alaska Alcoholic Beverage Control Board v. Decker*, 700 P.2d 483, 485 (Alaska 1985). However, the factual issue as to *which party* is truly the one trying to change the status quo can often be more difficult.

66 Federal Medicaid regulation 42 C.F.R. § 435.930 provides in relevant part that "[t]he agency must (a) Furnish Medicaid promptly to recipients without any delay caused by . . . administrative procedures; (b) *Continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible . . .*" [emphasis added].

67 For instance, in *Weaver v. Colorado Department of Social Services*, 791 P.2d 1230 (Colo. App. 1990), the petitioner appealed from a district court's judgment approving the Department of Social Services determination that the petitioner was no longer eligible to receive benefits under the Home and Community-Based Services program. *Id.* at 1231. The Colorado Court of Appeals addressed whether a change in an individual's physical or functional condition since he or she initially was determined to be eligible for benefits was required before the individual's right to such benefits could be terminated. *Id.* at 1234. The Colorado court stated:

> [C]ourts have concluded that, if an individual has once been determined... eligible for social service benefits, due process prevents a termination of those benefits absent a demonstration of a change in circumstances, or other good cause. The presumption that a condition, once shown to exist, continues to exist, as well as the considerations that underlie the doctrines of res judicata and collateral estoppel, require a showing of some change in circumstances if the termination of benefits is not to be deemed arbitrary. *See Byron v. Heckler*, 742 F.2d 1232 (10th Cir. 1984) . . . [and] *Trujillo v. Heckler*, 569 F. Supp. 631 (D. Colo. 1983).

68 *See* Section II(A) at page 3, above.

App. 1977). In *Balino*, the issue before the court was "who has the burden of proof at a reclassification hearing, the recipients of Medicaid benefits seeking continued assistance, or the Department of Health and Rehabilitative Services?" In that case, the Secretary of the Department of Health, Education and Welfare had promulgated regulations setting forth new and more restrictive criteria which Medicaid recipients had to meet in order to receive skilled nursing care. To comply with the new federal regulations, the Florida Department of Health and Rehabilitative Services (DHRS) then made changes to its own level-of-care definitions. DHRS then undertook a state-wide reclassification of its skilled care nursing home patients. The *Balino* court stated it was aware of no federal statutes or federal regulations which required Medicaid recipients, *once classified*, "to have thrust upon them the burden of proof as to their continued eligibility." The *Balino* court therefore held that DHRS bore the burden of proof.

The reasoning of the *Balino* court is sound and is consistent with 42 C.F.R. § 435.930, which requires that Medicaid eligibility, once established, continues absent a change in circumstances. Accordingly, it is appropriate that the Division bear the burden of proof as to the factual issues in this case.

E. The Preponderance of the Evidence Indicates that Ms. C Has Not Previously Received Dedicated One-on-One Staffing 24 Hours per day.

At hearing, Ms. C' Care Coordinator, E B, testified as to Ms. C' current receipt of, and future need for, 24-hour-a-day dedicated one-on-one staffing. Ms. B stated that one of the facility's staff is with Ms. C at all times except when Ms. C is asleep at night. Ms. B further testified that, at night, one of the two night-shift staff is dedicated to taking care of Ms. C.[69]

However, according to Ms. B's letter to DSDS dated May 26, 2011, the D J X H Home at that time had "a total of four residents, all requiring wheelchairs, living in the home."[70] Ms. B's letter further stated that "[t]here are 3 staff on duty from 7 am - 3pm and from 3pm - 11pm," and "2 staff on duty from 11pm - 7am."[71] Finally, one of the two night-time staff is normally asleep.[72] Thus, during the day the staff-to-patient ratio was 3:4, while at night that ratio fell to 2:4 (counting the sleeping staff member) and more realistically 1:4. Accordingly, as a matter of pure arithmetic, Ms. C was not previously receiving true 1-on-1 dedicated staffing either during

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69 E B hearing testimony (January 9, 2012 on direct examination).
70 Ex. F24.
71 Ex. F25.
72 Ex. K3.

the daytime or at night. The fact that Ms. C had not previously received dedicated one-on-one staffing on a continuous, 24-hour-a-day basis was essentially acknowledged by Ms. C in her post-hearing briefs.[73]

The parties differ greatly, however, on the meaning of the term *dedicated one-on-one staffing* used in the acuity rate regulation. Ms. C suggests that "dedicated one-on-one staffing" could include a situation in which the person normally tasked with caring for Ms. C would also have other responsibilities.[74] The Division asserts, on the other hand, that this would constitute only "interval care," and that "dedicated" staffing requires "direct care," which the Division essentially defines as constant hands-on care.[75]

As previously noted, Alaska's Waiver Services regulations do not define the term "dedicated one-on-one staffing." In the absence of a statutory or regulatory definition, the courts normally look to the dictionary to determine the meaning of terms in common usage.[76]

MacMillan's Online Dictionary defines "dedicated" in relevant part as "made or used for just one purpose."[77] Merriam-Webster's Online Dictionary defines "dedicated" in relevant part as "given over to a particular purpose."[78] Collins' Online Dictionary defines "dedicated" in relevant part as "devoted to a particular purpose or cause."[79] These definitions compel the conclusion that, although "dedicated one-on-one staffing" need not always be hands-on, it must always involve one staff member whose duties are devoted *entirely* to one *particular* resident.

In summary, based on the accepted definitions of "dedicated," it is clear that Ms. C has not previously received dedicated one-on-one staffing on a continuous, 24-hour-a-day basis. The final issue to be addressed is whether it is likely that Ms. C will be institutionalized in the future if the Division does not now provide her with such dedicated one-on-one staffing.

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[73] *See*, for example, Ms. C' Initial Post-Hearing Brief at 6 ("X, Ms. C's caregiver, was present with her at the first hearing and explained that someone is *generally* with Ms. C throughout the day on a one-on-one basis to make sure she is OK") (emphasis added).

[74] *See* Ms. C' Initial Post-Hearing Brief at 10.

[75] *See* the Division's Initial Post-Hearing Brief at 9-10 and the Division's Post-Hearing Reply Brief at 2-4.

[76] *Murray v. State*, 770 P.2d 1131 (Alaska App. 1989), citing *Walker v. State*, 742 P.2d 790, 791 (Alaska App.1987); *see also Government Employees Ins. Co. v. Dennis*, 645 P.2d 672, 675 (Utah 1982); *Keene v. Bonser*, 107 P.3d 693 (Utah App. 2005).

[77] *See* http://www.macmillandictionary.com/dictionary/british/dedicated (date accessed October 11, 2012).

[78] *See* http://www.merriam-webster.com/dictionary/dedicated (date accessed October 11, 2012).

[79] *See* http://www.collinsdictionary.com/dictionary/english/dedicated (date accessed October 11, 2012).

F. The Preponderance of the Evidence Indicates that Ms. C Will not be Institutionalized in the Absence of Dedicated One-on-One Staffing 24 Hours per day.

As previously indicated, there are two regulations, 7 AAC 145.520(m) and 7 AAC 130.230(f), which must be taken into account when determining the issue of whether Ms. C is entitled to receive an Acuity Add-On payment rate. First, 7 AAC 145.520(m) requires (as discussed above) that the recipient require "dedicated one-on-one staffing 24 hours per day." Second, 7 AAC 130.230(f) requires that a plan of care be approved only "if the department determines that each service listed on the plan of care . . . is of sufficient amount, duration, and scope to prevent institutionalization." Read together, these two regulations mean that Ms. C is entitled to receive an Acuity Add-On payment rate if she requires dedicated one-on-one staffing 24 hours per day in order to avoid institutionalization. In other words, Ms. C' needs must be intensive enough that she requires one staff person, devoted to her and her alone, 24 hours per day, in order to avoid institutionalization.

Regulation 7 AAC 130.230(f) is somewhat difficult to apply in that it ultimately requires the Department to predict the applicant or recipient's future. The regulation necessitates that the decision-maker try to foresee whether denying a requested waiver service to a recipient will cause the recipient to be placed in an institution.

The Department obviously cannot foretell the future. All that can be done is to determine whether it is more probable than not, based on Ms. C' past Waiver Services usage history, whether denying the dedicated one-on-one staffing requested here will cause Ms. C to be placed in an institution.

It is clear from the record that Ms. C has severe mental and physical impairments and that she has a substantial need for numerous waiver services. However, it is equally clear that, for at least the past three to four years, Ms. C has not received dedicated one-on-one staffing provided 24 hours per day. The lack of this dedicated staffing has not caused her to be institutionalized to date, and Ms. C' Care Coordinator testified that her condition is relatively stable (*i.e.* that her condition is not currently deteriorating). Accordingly, because Ms. C has not been institutionalized *in the past* due to a lack of dedicated one-on-one staffing, it is more probable than not that Ms. C will not be institutionalized *in the future* due to a lack of dedicated one-on-one staffing.[80]

[80] Should Ms. C' condition deteriorate in the future, she may then re-apply for the Acuity Add-on.

IV. Conclusion

The Division met its burden and proved, by a preponderance of the evidence, that Ms. C does not currently require "dedicated one-on-one staffing 24 hours per day" in order to avoid institutionalization. The Division was therefore correct when it denied that portion of Ms. C' proposed renewal Plan of Care which requested the Acuity Add-on rate.

DATED this 12th day of October, 2012.

Signed
Jay Durych
Administrative Law Judge

Adoption

The undersigned, by delegation from of the Commissioner of Health and Social Services, adopts this Decision, under the authority of AS 44.64.060(e)(1), as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 9th day of November, 2012.

By: *Signed*
Name: Kimberli Poppe-Smart
Title: Deputy Commissioner
Agency: DHSS

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