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

In the Matter of	)	
	)	
S H	)	OAH No. 12-0645-MDS
	)	Division No.

DECISION

I. Introduction

S H receives Medicaid Home and Community-Based Waiver program ("Waiver") services. The Department of Health and Social Services, Division of Senior and Disabilities Services ("Division") approved him to receive an Acuity Add-On rate as part of his Waiver Plan of Care that ended January 23, 2012.[1] When he applied to renew his Waiver Plan of Care, the Division notified him that the portion of his Waiver Plan of Care providing for an Acuity Add-On rate was disapproved.[2] Mr. H requested a hearing.[3]

Mr. H's hearing was held on September 11, 2012. He was represented by Mark Regan with the Disability Law Center. Kimberly Allen, Assistant Attorney General, represented the Division. The hearing was recorded.

This decision concludes that Mr. H does not require the "dedicated one-on-one staffing 24 hours per day" necessary to receive an Acuity Add-on rate. The Division's decision terminating his Acuity Add-on rate is AFFIRMED.

II. Facts

Mr. H is a severely disabled man in his early 50s who lives in a group home. He has extensive care needs. He suffers from severe mental retardation, spastic quadriplegia, dementia, scoliosis, incontinence, and has a history of seizures. He is non-verbal, non-ambulatory, and has difficulty expressing his needs, including when he has incontinent episodes. He has difficulty eating, and experiences choking and vomiting. He is completely dependent upon others for his activities of daily living.[4]

The group home where Mr. H lives has other severely disabled people in it. When his plan of care was being reviewed, there were three residents in the group home.[5] As of the hearing date, there

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1 Ex. E, p. 1.
2 Ex. D, pp. 1 - 2.
3 Ex. C.
4 Ex. F, pp. 4, 6, 8.
5 Teresa Rosso testimony.

were four residents in the home.[6] The staffing schedule for March 2012 showed two staff for the night shift, versus three staff for the day (7 a.m. to 3 p.m.) and evening (3 p.m. to 11 p.m.) shifts.[7]

Mr. H's schedule provides that he is to be checked for incontinence every hour and repositioned every other hour during the nighttime hours.[8] Staff are supposed to check on him at least once an hour.[9] His actual care logs for the month of January 2012 consistently document that he was checked upon every other hour and repositioned every two hours between 11 p.m. and 7 a.m.[10] The checking upon and repositioning is not part of a continuous observation process as shown by the care log for the night shift for January 7, 2012, which states that Mr. H "was up when I was conducting my last round approximately 6 a.m."[11] In addition, Mr. H's January 24, 2012 – January 13, 2013 proposed plan of care "states that "[h] e requires to be repositioned every two hour to prevent bed sores on his body, especially at night. Additionally, his provider checks on him frequently between turns to gauge his breathing and well-being."[12]

Mr. H receives Medicaid Waiver services under the mental retardation or developmental disability (MRDD) category. He was approved to receive an Acuity Add-On rate as part of his 2011–2012 Waiver Plan of Care.[13] He applied to renew his Waiver Plan of Care for the period from January 24, 2012 through January 3, 2013. His 2012 – 2013 Waiver Plan of Care stated that he requires a "1:1 staffing ratio 24 hours per day" and requested that he continue to receive an Acuity Add-On rate.[14] While the Division approved his Waiver Plan of Care renewal, it denied the request for a continued Acuity Add-On rate. In the denial letter, the Division stated "[t]here is not sufficient information with the provided documentation that [Mr. H] requires assigned one-to-one staffing dedicated to his care 24 hours a day. . . For the past [Plan of Care] year, [Mr. H] has received monitoring and interval care through the night but has not shown a medical need for through the night one-to-one direct care and services. . ." The Division's denial letter quoted from Alaska regulation 7 AAC 145.520(m) and further stated that "[d]irect care needs and services are not evident beyond this interval care . . ."[15]

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6 Rosso testimony.
7 Ex. L, p. 27.
8 Ex. I, p. 48.
9 E B, direct care coordinator, testimony.
10 Ex. I, pp. 7, 13, 19, 25, 29, 33, 39, 45, 54; Ex. J, pp. 4, 6, 16, 20, 26, 32, 38, 44; Ex. K, pp. 14, 25, 33, 38, 44.
11 Ex. K, p. 14.
12 Ex. F, p. 6.
13 Ex. E, p. 1; Ex. F, pp.
14 Ex. F, p. 13.
15 Ex. D, p. 2.

III. Discussion

The Medicaid program has a number of coverage categories. One of those coverage categories is the Waiver program.[16] The Medicaid program pays for specified individual services to Waiver recipients.[17] The Division must approve each specific service as part of the Waiver recipient's plan of care.[18] A Waiver recipient's plan of care is subject to review on a yearly basis.[19] A Waiver recipient who receives group home habilitation services may receive an Acuity Add-On rate, which is paid to the provider.[20] In order to qualify for the Acuity Add-On rate, a recipient's Waiver plan of care must "document[] and require[] that the recipient receive dedicated one-on-one staffing 24 hours per day."[21]

As noted previously, Mr. H was provided the Acuity Add-On rate as part of his approved 2011 – 2012 plan of care and then denied it for his subsequent plan of care. The resulting issue is whether Mr. H should continue to receive an Acuity Add-On rate. Because this case involves the termination of a specific benefit, the Division has the burden of proof by a preponderance of the evidence.[22]

Mr. H argued that his Acuity Add-On rate should not be denied for three separate reasons: first, that the termination notice was inadequate; second, that his condition had not materially improved; and third, that he required "dedicated one-one-one staffing 24 hours per day." Each of these is addressed separately below.

A. Notice

The Alaska Supreme Court has stated that public assistance benefit recipients are entitled to adequate notice detailing the reasons for an agency action that modifies benefits:

> If a major purpose served by benefit change or denial notices is protecting recipients from agency mistakes, then it stands to reason that such notices should provide sufficient information to allow recipients to detect and challenge mistakes.[23]

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16 7 AAC 100.002(d)(8); 7 AAC 100.502(d).

17 7 AAC 130.230(c).

18 7 AAC 130.230(f).

19 7 AAC 130.230(g).

20 7 AAC 145.520(m). All references to 7 AAC 145.520(m) are to the version of the regulation that was in effect before April 1, 2012.

21 7 AAC 145.520(m).

22 A party who is seeking a change in the status quo has the burden of proof by a preponderance of the evidence. *State, Alcoholic Beverage Control Bd. v. Decker*, 700 P.2d 483, 485 (Alaska 1985); *Amerada Hess Pipeline Corp. v. Alaska Pub. Util. Comm'n*, 711 P.2d 1170, n.14 at 1179 (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).

23 *Allen v. State, Dept. of Health and Social Serv., Div. of Pub. Assistance*, 203 P.3d 1155, 1168 (Alaska 2009).

The Alaska Fair Hearing regulations require that written notices notifying a recipient of benefit changes or denials "must detail the reasons for the proposed adverse action, including the statute, regulation, or policy upon which that action is based."[24]

A review of the Acuity Add-on rate termination notice sent to Mr. H shows that it complied with these requirements. It referred to the applicable regulation, 7 AAC 145.520(m), and stated "[t]here is not sufficient information with the provided documentation that [Mr. H] requires assigned one-to-one staffing dedicated to his care 24 hours a day . . . . For the past [Plan of Care] year, [Mr. H] has received monitoring and interval care through the night but has not shown a medical need for through the night one-to-one direct care and services . . . ." It further stated that "[d]irect care needs and services are not evident beyond this interval care . . . ."[25] This notice provided Mr. H with "sufficient information to allow [him] to detect and challenge mistakes." Consequently, Mr. H's argument that the notice was deficient is not persuasive.

B. Improvement

The Division, by statute, is not allowed to terminate previously approved Waiver "services" provided for a Waiver recipient unless his annual assessment finds that his "condition has materially improved since [his] previous assessment."[26] The applicable statute defines "material improvement" for an MRDD Waiver recipient as meaning that the recipient's "qualifying diagnosis has changed or that the recipient is able to demonstrate the ability to function in a home setting without the need for waiver services."[27]

Mr. H's diagnosis has not changed. His complex medical conditions and his complete dependence upon others for all of his care needs undeniably establish that he could not "function in a home setting without the need for waiver services." He argues, as a result, that the Division is statutorily barred from terminating the Acuity Add-On rate paid through his participation in the Waiver program.

Mr. H's argument is a purely legal one which involves statutory interpretation. There are two possible interpretations of the applicable statute, AS 47.07.045(b)(3)(B). One interpretation would require that a specific Waiver service, once approved, be provided continuously unless a Waiver recipient's condition improved to the point that he no longer qualified for the Waiver services as a

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24 7 AAC 49.070.
25 Ex. D, p. 2.
26 AS 47.07.045(b)(3).
27 AS 47.07.045(b)(3)(B).

whole. Such an interpretation would require that a specific service be continued indefinitely, even if the need for it no longer exists or if it was initially approved in error.

The other way to interpret the statute is to read the prohibition against termination for payment of "services" as referring to "home and community-based services" as a whole, *i.e.*, the Division cannot terminate a person's eligibility for "home and community-based services" unless the new assessment demonstrates that he no longer qualifies for those "services." Under this interpretation, the Division can terminate a specific service, but cannot terminate Waiver services as a whole unless a Waiver recipient, as measured by the annual assessment, is no longer eligible for Waiver services in their entirety.

Alaska courts interpret statutes based on reason, practicality, and common sense, while taking into account the plain meaning of the words used, the purpose of the law, and the intent of the drafters.[28] Bearing this rule of interpretation in mind, the second interpretation of the statute is the most reasonable. The Division may terminate a specific "service" paid for by the Waiver program, but may not terminate Waiver "services" as a whole unless a Medicaid Waiver recipient's annual assessment demonstrates that he longer qualifies for the Waiver services. This conclusion is reached at for the following reasons:

1. The statute, AS 47.07.045, only uses the plural term "services." It says that an applicant will be approved for "home and community-based services."[29] It says those "services" may only be terminated if the recipient's annual assessment shows the recipient no longer has the need for "waiver services."[30] If the statute meant to refer to a specific service, as compared to eligibility for Medicaid Waiver services as a whole, the statute would not have used the plural term "services;" the Legislature could more precisely have used the phrase "a waiver service."
2. Construing the statute, AS 47.07.045, to prohibit termination of a specific approved service would lead to the result that every service be continued when a Waiver recipient should not have received that specific service to begin with, or no longer requires uses a specific service, as long as the Claimant qualified for Waiver services overall. For example, a Waiver recipient receiving private-duty nursing services[31] would continue to receive those services, even if his condition improved to the point he no longer required such services, as long as he remained

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28 *Young v. Embley*, 143 P.3d 936, 939 (Alaska 2006).
29 AS 47.07.045(a).
30 AS 47.07.045(b) and (b)(3)(B).
31 *See* 7 AAC 130.285.

eligible for the overall program. This would be a wasteful result and one that would not further the purposes of the statute.

As a result, even though a Waiver recipient's condition has not "materially improved," and he qualifies for Waiver services as a whole, the Division may legally terminate a specific Waiver service.

C. Dedicated one-on-one staffing

The critical factual issue here is whether Mr. H meets the regulatory requirements for receiving an Acuity Add-On rate, which is that his Medicaid Waiver plan of care must "document[] and require[] that the recipient receive dedicated one-on-one staffing 24 hours per day."[32] The regulations do not define the term "dedicated one-on-one staffing." In the absence of a statutory or regulatory definition, tribunals commonly look to the dictionary to determine the meaning of terms in common usage.[33]

MacMillan's Online Dictionary defines "dedicated" in relevant part as "spending all your time or effort on something" and as "made or used for just one purpose."[34] Merriam-Webster's Online Dictionary defines "dedicated" in relevant part as "given over to a particular purpose."[35] Collins' Online Dictionary defines "dedicated" in relevant part as "devoted to a particular purpose or cause."[36] The definition of "dedicated" can therefore mean both "exclusively available to" and "earmarked and available to." When the term "dedicated" is combined with the term "one-on-one," the regulation means exclusively dedicated, i.e. the staff member's duties are devoted *entirely* to one *particular* resident.

The facts of this case demonstrate that Mr. H does not receive dedicated one-on-one staffing 24 hours per day for the following reasons:

- His schedule provides that he is to be checked for incontinence every hour and repositioned every other hour during the nighttime hours.[37]
- Staff are supposed to check on him at least once an hour.[38]
- His 2012 – 2013 Waiver plan of care provides that he is to be checked on "frequently between turns to gauge his breathing and well-being."[39]

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32 7 AAC 145.520(m).

33 *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).

34 *See* http://www.macmillandictionary.com/dictionary/british/dedicated (date accessed November 8, 2012).

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

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

37 Ex. I, p. 48.

38 E B, direct care coordinator, testimony.

- His daily care logs consistently document that he was checked upon every other hour and repositioned every two hours between the hours of 11 p.m. and 7 a.m.[40]

While Mr. H is observed, checked upon, and repositioned frequently during the nighttime hours, these occur intermittently, and do not constitute continuous attendance upon him. This does not satisfy the regulation's stringent requirement that he require "dedicated one-on-one staffing 24 hours per day."[41] Consequently, the Division has met its burden of proof and established that Mr. H is not eligible for an Acuity Add-On rate.

IV. Conclusion

Mr. H does not satisfy the requirements for receiving an Acuity Add-On rate. As a result, the Division's decision to deny that portion of his 2012 – 2013 Medicaid Waiver plan of care which requested that he continue to receive an Acuity Add-On rate is AFFIRMED.

DATED this 8th day of November, 2012.

Signed
Lawrence A. Pederson
Administrative Law Judge

Adoption

The undersigned, by delegation from 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 19th 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.]

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39 Ex. F, p. 6.
40 Ex. I, pp. 7, 13, 19, 25, 29, 33, 39, 45, 54; Ex. J, pp. 4, 6, 16, 20, 26, 32, 38, 44; Ex. K, pp. 14, 25, 33, 38, 44.
41 7 AAC 145.520(m).