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

In the Matter of:	)	
	)	
S N	)	OAH No. 14-0540-MDS
	)	Agency No.

DECISION

I. Introduction

The issue in this case is whether S N is entitled to receive a higher-than-normal level of Medicaid funding, known as an acuity rate or acuity payment, to fund dedicated one-on-one staffing for him at his assisted living facility (ALF). This decision concludes, based on the evidence presented, that Mr. N's ALF has not previously provided him with dedicated one-on-one, 24-hour-per-day staffing, that Mr. N's condition has not deteriorated in a way that increases his care needs, and that Mr. N has not been institutionalized due to the lack of continuous one-on-one staffing. The preponderance of the evidence thus indicates that Mr. N does not currently require dedicated one-on-one, 24-hour-per-day support to avoid being institutionalized. Accordingly, the Division of Senior and Disabilities Services (DSDS or Division) was correct when it denied that portion of Mr. N's proposed Plan of Care renewal which requested an acuity payment. The Division's decision is therefore affirmed.

II. Facts

A. Mr. N's Medical Condition and Impairments

Mr. N is a 66 year old man who has lived at The No Name, an assisted living facility (ALF), since 2011.[1] He was previously employed in many capacities including those of laborer, dump truck driver, and volunteer fire fighter, and was well known for his mechanical aptitude with cars, bikes, and boats.[2] He began to experience memory problems while in his 50s which, at that time, were believed to be stroke-related.[3] Mr. N's wife T took excellent care of him at home until it became too difficult for her to care for Mr. N by herself, at which time Mr. N was admitted to an ALF.[4]

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1 Exs. E5 and E9; E X's hearing testimony.
2 Ex. E9.
3 Ex. E9.
4 Ex. E9.

Mr. N is still physically functional, but has Alzheimer's disease and continues to decline cognitively.[5] He is unable to communicate well and speaks "word salad."[6] He has had behavioral problems which ALF staff have not been able to alter. He is often up at night and is a wanderer. He is sometimes anxious and agitated, and at those times he can be combative. Trained caregivers are necessary to deal with this behavior, and a sedative has been prescribed for Mr. N for use as necessary. He is able to follow prompting by staff most of the time. On some days Mr. N is exhausted and sleeps most of the day; at these times he cannot be awakened or moved by the ALF staff. On his more energized days he is able to walk with the assistance of a gait belt. He sometimes has seizures. He requires thickened and pureed foods and must be supervised while eating.

When Mr. N's valproic acid levels are correct, he does not have as many behavioral issues.[7] When his valproic acid levels are low, he is very combative and is at risk of hurting himself and others. He is too large and too strong for the ALF's staff to effectively intervene. The ALF staff must constantly monitor Mr. N to keep him from urinating in inappropriate places.

Mr. N became unsteady with standing and walking at the end of 2012, he began to have more frequent falls, and it became necessary for the ALF staff to assist him in walking at all times.[8] He is unable to use a walker. In February 2013 the ALF staff noticed a change in Mr. N's sleeping habits.[9] He started sleeping more and would not wake up to eat or have his briefs changed. On April 13, 2013 Mr. N had a seizure, was taken to the emergency room, was given Ativan, and was released later that day. His Depakote prescription was increased at this time. On April 15, 2013 Mr. N was admitted to the hospital because he had been in a sedated state for two days. He was observed and released two days later.

In early June 2013 Mr. N's Depakote prescription was decreased and he became more aware but also more agitated.[10] On June 16, 2013 Mr. N had another seizure, was taken to the hospital, and was released soon thereafter. On June 26, 2013 Ms. N advised the ALH staff that her husband had begun to have swallowing problems. On June 28, 2013 Mr. N's physician visited the ALF and

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[5] All factual findings in this paragraph are based on Ex. E9 and Sharon N's hearing testimony unless otherwise stated.

[6] "Word salad" is a term referring to incoherent speech consisting of both real and imaginary words, lacking comprehensive meaning, often occurring in advanced schizophrenic states. See Random House Dictionary definition, accessed online at http://dictionary.reference.com/browse/word+salad (accessed on June 18, 2014).

[7] Ex. E12.

[8] All factual findings in this paragraph are based on Ex. E6 unless otherwise stated.

[9] Kelly Jones testified that this is a typical symptom of persons suffering from advanced stages of dementia.

[10] All factual findings in this paragraph are based on Ex. E6 unless otherwise stated.

advised the staff as to procedures to be followed when Mr. N has a seizure. On July 7, 2013 Mr. N was taken to the hospital because he again would not wake up to eat nor have his briefs changed. He was found to have a lung infection and was not released from the hospital until July 24, 2013. He became very weak during this time due to not eating or getting out of bed for about ten days. As of August 2013 Mr. N continues to have difficulty swallowing, his food is pureed, and can only consume liquids that have been thickened.

The Division received no Critical Incident Reports for Mr. N during the last plan of care year.[11] Ms. N testified at hearing that she believes the ALF staff have been able to properly care for her husband and keep him safe over the past year. She is greatly concerned, however, that if her husband loses the acuity rate, he will not be able to remain at The No Name, and that (in turn) if he cannot live at The No Name, he will not be accepted at an ALF elsewhere.

Kelly Jones is a licensed Masters-level social worker and dementia specialist employed by the Alzheimer's Association of America.[12] She has published articles on neuropsychiatric issues in medical / scientific journals. She provides both direct care to patients suffering from dementia, and training for persons working with such patients. She has observed Mr. N at his ALF. Based on her recommendations the ALF has implemented certain procedures and made certain environmental modification to the ALF in order to improve Mr. N's safety and that of the ALF staff working with him. Ms. Jones testified that the ALF provides Mr. N with very good care and that his neuropsychiatric condition has stabilized over the last year due to the quality of the care provided by the ALF. She stated that Mr. N's physical condition and strength have declined during the last year, but that he is still strong enough to hurt himself and others when he becomes agitated. Ms. Jones testified that, if the acuity rate is withdrawn, Mr. N "will be in a crisis situation."

B. The Assisted Living Facility

The No Name is an assisted living facility located in No Name.[13] Mr. N has lived there since 2011.[14] As of May 2014 there were 12 residents living at The No Name, one of these being Mr. N.[15] The other 11 residents have dementia or Alzheimer's but are comparatively high-

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[11] Annette Callies hearing testimony. Kelly Jones testified that this is a direct result of the quality care Mr. N receives at The No Name.

[12] All factual findings in this paragraph are based on Kelly Jones' hearing testimony unless otherwise stated.

[13] Ex. K2.

[14] E X hearing testimony.

[15] Annette Callies hearing testimony. Ms. X likewise testified that there have always been 11-12 residents at The No Name at any one time.

functioning; Mr. N "is at the other end of the spectrum."[16] When Mr. N needed to be placed in an ALF, The No Name was the only facility in Alaska that would accept him due to his care requirements.[17] The No Name keeps detailed records regarding its observation and care of its residents.[18] The No Name submitted its daily observation and care records for Mr. N to the Division for the Division's review in this case.[19]

The No Name's staffing schedule at all times relevant here[20] has been as follows: one staff member who works from 7:30 a.m. - 3:30 p.m.; a second staff member who works from 8:00 a.m. - 4:00 p.m.; a third staff member who works from 3:30 p.m. - 11:30 p.m.; a fourth staff member who works from 4:00 p.m. - 12:00 a.m.; and a fifth staff member who works from 12:00 a.m. - 8:00 a.m.[21] With these overlapping shifts, there is always one person on duty each day from 11:30 p.m. - 7:30 a.m., and two people on duty each day from 7:30 a.m. - 11:30 p.m. Thus, there are two people on duty to serve the 11-12 residents during the morning, daytime, and evening, but only one person on duty to serve those residents during the "overnight" shift.[22]

E X is The No Name's administrator.[23] She has been an ALF administrator for over 20 years. She has operated her current facility, The No Name, for the last 12 years. She testified that The No Name normally has one person assigned to watch or assist Mr. N during the morning, daytime, and evening, leaving one other staff person available for the other residents at those times.[24] She has been forced to come in to personally assist her staff with Mr. N's care at certain times, such as when Mr. N has fallen.

Ms. X testified that her ALF will not be able to properly care for Mr. N without the acuity rate.[25] Ms. X believes that, without the acuity rate, Mr. N will not be accepted at any other ALF and will need to be placed in a nursing home.

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16 E X hearing testimony.
17 E X hearing testimony.
18 *See* Exs. G through S.
19 *See* Exs. G through S.
20 Ms. X testified that The No Name recently hired some additional staff, but the increased staffing became effective after the date the Division made its determination as to Mr. N's proposed renewal plan of care.
21 Ex. F1.
22 E X hearing testimony.
23 All factual findings in this paragraph are based on E X's hearing testimony unless otherwise stated.
24 Ms. X testified that, during the daytime, she has one staff person assigned to Mr. N at "every waking minute," and that, at night, she has one staff person dedicated to Mr. N's observation and care approximately "45 minutes out of every hour," or about 75% of the time.
25 All factual findings in this paragraph are based on E X's hearing testimony unless otherwise stated.

C. Relevant Procedural History

Mr. N has received Medicaid Home and Community-Based Waiver Services through the "Alaskans Living Independently" (ALI) waiver services program since sometime prior to 2013.[26] On September 10, 2013 Mr. N's Care Coordinator submitted a proposed plan of care renewal to DSDS covering the period October 9, 2013 through October 8, 2014.[27] The plan of care renewal sought Care Coordination services, Residential Living services, and the Acuity Rate.[28]

On April 3, 2014 the Division approved the proposed POC in part and denied it in part.[29] The Division approved that portion of the proposed POC renewal seeking 365 units of Residential Supported Living services, and 190 units of the Acuity Rate for the period from October 9, 2013 through April 16, 2014.[30] The Division denied that portion of the proposed POC renewal seeking 175 units of the Acuity Rate covering the period from April 17, 2014 through October 8, 2014.[31] The Division's April 3, 2014 notice stated in relevant part as follows:[32]

> The Division denies the [Acuity Rate] under the authority of 7 AAC 130.217, 7 AAC 130.267, [and] 7 AAC 160.200 . . . .
> . . . .
>
> The staffing schedule provided to [the Division] indicates that only one staff member was scheduled to provide care for up to 12 residents in the assisted living home for the overnight schedule from 12:00 p.m. to 8:00 a.m. This clearly shows that one to one staffing, which is a requirement of the acuity rate, has not been provided to this recipient for the last year and yet he remained safe at the ALH.
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> Another justification stated in the [POC] for requesting the acuity rate is due to the behavioral challenges. The care calendar and activity logs from the [ALH] for the last 30 days do not record challenging behavior. It appears that [Mr. N] sleeps well . . . . In addition it was noted in the supporting medical documentation dated 9-18-2013 by A L. B, M.D. [that] "[a]t one point a couple years ago, [Mr. N] had a lot of problems, with severe agitation [but that] a psychiatric hospitalization resulted in him being placed on Depakote [and that] since then he has not had major behavioral issues" . . . .
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[26] Ex. E2,

[27] Ex. E2.

[28] Exs. E11 - E12.

[29] Exs. D1 – D3.

[30] The Acuity Rate units approved by the Division were for the portion of the POC year / period which had already elapsed prior to the Division's issuance of its partial approval / partial denial letter in April 2014.

[31] Ex. D1. The Care Coordination services requested by in the proposed POC renewal were not specifically denied, and so were presumably approved. In any event, those services are not at issue in this case.

[32] Exs. D1 - D3.

> The Plan of Care and 24 hour care calendar provided to [DSDS] indicates that the care [provided] to the recipient consists of activities of daily living and instrumental activities of daily living - which is the regular care that is expected to be provided to any resident in an assisted living home. It appears that with 12 clients served at the time of the [POC renewal] request, [Mr. N's] intermittent direct care needs are met, with the current staffing, [with the current] supported living service which has prevented institutionalization. The requested Acuity add-on is denied because the level of assistance needed and provided for Mr. N is already met through Residential Supported Living service. This service already provides staffing 24 hours per day, 7 days per week for his care. All residential supported living recipients demonstrate the need for assistance on a 24 hour basis; the assisted living homes already receive a base rate for that service. Dedicated one-to-one staff is a much higher level of care . . . . Residential supported living service is of sufficient amount, duration, and scope to prevent institutionalization . . . .

Mr. N's wife and guardian requested a hearing on Mr. N's behalf on April 7, 2014.[33]

Mr. N's hearing was held on May 5, 2014. Mr. N was represented by his wife and legal guardian T N; she participated by phone and testified on behalf of her husband. E X, Facility Administrator of Mr. N's ALF, and Kelly Jones, a Masters-level social worker, also participated in the hearing by phone and testified on Mr. N's behalf.

The Division was represented by Victoria Cobo, who participated by phone. Annette Callies, a Health Program Manager II for DSDS, participated by phone and testified on behalf of the Division. DSDS hearing representative Angela Ybarra observed the hearing for training purposes. The record closed at the end of the hearing.

III. Discussion

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

The Medicaid program has a number of coverage categories. One of those coverage categories is the Home and Community-Based Waiver Services program[34] ("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.[35]

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33 Ex. C.

34 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.*

35 *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:

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 individuals in an institutional setting.[36] Any failure to abide by this requirement will result in CMS' termination of the state's waiver services program.[37] 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.[38]

Alaska participates in the waiver services program.[39] Alaska's program pays for specified individual services for recipients.[40] The Division must approve each specific service as part of a recipient's Plan of Care (POC).[41] Services must be "of sufficient amount, duration, and scope to prevent institutionalization."[42] A recipient's plan of care is subject to review on an annual basis.[43]

At the time Mr. N's renewal plan of care was submitted to the Division on September 10, 2013,[44] the standards for approval of a plan of care renewal or amendment request were contained in 7 AAC 130.217, (still in effect now), which provides in relevant part as follows:

> (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].

36 *See* 42 U.S.C. § 1396n(c)(2)(D).

37 See 42 U.S.C. § 1396n(f)(1).

38 *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 particular needs).

39 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 USC 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 . . . .

40 7 AAC 130.240 - 7 AAC 130.305.

41 7 AAC 130.209, 7 AAC 130.217.

42 7 AAC 130.217(b).

43 7 AAC 130.213.

44 The Division's position statement and its partial denial letter dated April 3, 2014 state that Mr. N's POC was submitted on May 22, 2013. However, Mr. N's renewal POC is date-stamped as received by the Division on September

> (b) The department will approve a plan of care if the department determines that (1) *the services specified in the plan of care are sufficient to prevent institutionalization and to maintain the recipient in the community; (2) each service listed on the plan of care (A) is of sufficient amount, duration, and scope to meet the needs of the recipient;* (B) is supported by the documentation required in this section; and (C) cannot be provided under 7 AAC 105 - 7 AAC 160, except as a home and community-based waiver service . . . [Emphasis added].

The prior version of the regulation, 7 AAC 130.230(g), provided in relevant part as follows:[45]

> A recipient's need for home and community-based waiver services must be reviewed annually using the same criteria used to determine initial eligibility under 7 AAC 130.205 . . . . 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 . . . . [Emphasis added].

As noted above, 7 AAC 130.217 is the regulation which applies to this case. However, both the old standard (7 AAC 130.230(g)) and the new standard (7 AAC 130.217(b)) set the minimum plan of care service level at those services which are sufficient to meet the needs of the recipient and prevent the recipient's institutionalization. There is thus no substantive difference between the old and new regulations as applied here, and the same result would obtain under either regulation.

B. Alaska's Acuity Rate / Acuity Payment Regulation

The regulation currently governing the acuity rate in Alaska is 7 AAC 130.267, which provides in relevant part as follows: [46]

> (a) The department will approve an acuity payment for additional services (1) for a recipient who is (A) eligible for and receiving (i) residential supported-living services . . . or

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10, 2013 (Ex. E2). The renewal POC was not signed by the recipient and Care Coordinator until September 9, 2013 (Ex. E18). Accordingly, it is clear that the actual submission date of the renewal POC was September 10, 2013.

[45] 7 AAC 130.230 was adopted on February 1, 2010 and was the regulation in effect at the time the Division's partial denial letter (Ex. D) indicates Mr. N's renewal plan of care was received (May 22, 2013). Since then, 7 AAC 130.230 has been repealed and replaced by 7 AAC 130.205, 7 AAC 130.211, 7 AAC 130.213, 7 AAC 130.215, 7 AAC 130.217, and 7 AAC 130.219, all effective July 1, 2013 (see Register 206). As indicated in the preceding footnote, Mr. N's renewal POC was not actually submitted until September 10, 2013. Because 7 AAC 130.217 was the regulation in effect at the time the Division received Mr. N's renewal plan of care, it is the regulation that must be followed in this case. *See In re E.D.,* OAH No. 13-1369-MDS (Commissioner of Health and Social Services 2014) at page 2; *see* also *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).

[46] As discussed above, the regulation which applies in this case is the version of 7 AAC 130.267 that was in effect at the time Mr. N's renewal plan of care was submitted. That version, quoted above, became effective on July 1, 2013 (Register 206). However, the changes effective by the amendment were technical rather than substantive. Accordingly, there is no substantive difference between the old and new versions of 7 AAC 130.267 as applied to this case, and the same result would obtain under either regulation.

(ii) group-home habilitation services . . . and (B) a qualified recipient under (b) of this section . . .

(b) For purposes of this section, 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 130.217; 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.* [Emphasis added].

. . . .

(f) The department will not give prior authorization under this section for more than 12 consecutive months. The department may terminate authorization at any time if the department verifies that the recipient's physical condition or behavior no longer requires additional services under this section.

C. Applicable Burden of Proof and Standard of Review

Pursuant to federal Medicaid regulation 42 C.F.R. § 435.930, Medicaid eligibility, once established, continues until a change in circumstances is demonstrated by the Division.[47] Accordingly, the Division bears the burden of proof on all disputed factual issues in this case.[48]

The standard of review in a Medicaid "Fair Hearing" proceeding, as to both the law and the facts, is *de novo* review.[49] In this case, evidence was presented at hearing that was not available to the Division's reviewers. The administrative law judge may independently weigh the evidence and reach a different conclusion than did the Division's staff, even if the original decision is factually supported and has a reasonable basis in law. Likewise, the Commissioner is not required to give deference to factual determinations or legal interpretations of his staff.

D. The Preponderance of the Evidence Indicates that Mr. N Has Not Previously Received Dedicated One-on-One Staffing 24 Hours per day.

At hearing, E X, the administrator of Mr. N's ALF, testified as to Mr. N's current level of services at the ALF. She testified that The No Name normally has one person assigned to watch or assist Mr. N during the morning, daytime, and evening (at "every waking minute"), leaving one other staff person available for the other residents at those times. Ms. X further testified, however, that at night she has one staff person dedicated to Mr. N's observation and care approximately "45

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[47] 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].

[48] *See also* the Alaska Department of Health and Social Services' "Fair Hearings" regulation 7 AAC 49.135.

[49] *See* 42 CFR 431.244; *Albert S. v. Dept. of Health and Mental Hygiene*, 891 A.2d 402 (2006); *Maryland Dept. of Health and Mental Hygiene v. Brown*, 935 A.2d 1128 (Md. App. 2007); *In re Parker*, 969 A.2d 322 (N.H. 2009); *Murphy v. Curtis*, 930 N.E.2d 1228 (Ind. App. 2010).

minutes out of every hour," or about 75% of the time. This constitutes a very high level of supervision and care, and for this Ms. X is to be commended. However, the acuity rate regulation, 7 AAC 130.267, requires one-on-one support, from a worker whose time is dedicated solely to providing services to Mr. N, for 24 hours per day, seven days per week. Anything less fails to satisfy the requirements of the regulation.

In summary, it is clear that Mr. N 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 Mr. N will be institutionalized if the Division does not now provide him with such dedicated one-on-one staffing.

E Past History Indicates that Mr. N 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 130.267 and 7 AAC 130.217, which must be taken into account when determining the issue of whether Mr. N is entitled to receive the acuity payment rate. First, 7 AAC 130.267 requires (as discussed above) that the recipient require dedicated one-on-one staffing 24 hours per day. Second, 7 AAC 130.217(b) allows the Division to approve those services in a plan of care which are "sufficient to prevent institutionalization and to maintain the recipient in the community," and which are "of sufficient amount, duration, and scope to meet the needs of the recipient."[50] Cumulatively, these two regulations mean that Mr. N is entitled to receive the acuity payment rate if he requires dedicated one-on-one staffing 24 hours per day in order to avoid institutionalization. In other words, Mr. N' needs must be intensive enough that he requires one staff person, devoted to him and him alone, 24 hours per day, in order to avoid institutionalization.

Regulation 7 AAC 130.217(b) is somewhat difficult to apply in that it ultimately requires the Division (and the administrative law judge) 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.

Obviously, neither the Division nor the administrative law judge can foretell the future. All that can be done is to determine whether it is more probable than not that Mr. N will need to be placed in an institution if he does not receive dedicated one-on-one staffing 24 hours per day.

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[50] As indicated by the text of the regulation, there are two facets to 7 AAC 130.217(b). The services provided must be *no less* than required "to prevent institutionalization and to maintain the recipient in the community," and yet *no more* than are necessary "to meet the needs of the recipient."

It is clear from the record that Mr. N has severe mental and physical impairments, that he requires a high level of care, and that he has received a much greater level of supervision and attention than the rest of The No Name's current residents. However, it is equally clear that, for at least the past year, Mr. N has not received dedicated one-on-one staffing provided 24 hours per day. This lack of this dedicated staffing has not caused Mr. N to be institutionalized to date. Further, Ms. Jones testified that, although Mr. N is currently still strong enough to hurt himself and others when he becomes agitated, his physical strength and condition have declined during the last year. If this trend continues, which appears likely based on the parties' testimony, Mr. N will actually become less of a danger to himself and others, and have less of a need for dedicated one-on-one care. Accordingly, although it is a close question, it is more probable than not, based on the evidence in the record, that Mr. N will not be institutionalized in the future due to a lack of dedicated one-on-one staffing.[51]

F. Neither the Division nor the Administrative Law Judge has the Authority to Create Exceptions to the Acuity Rate Regulation

At hearing Ms. N, Ms. X, and Ms. Jones all testified convincingly that Mr. N requires a high level of care and that, as an economic matter, The No Name will be unable to continue providing Mr. N with that level of care without the acuity rate payment. However, the Division is required to follow its waiver services regulations as currently written.[52] Likewise, the Office of Administrative Hearings does not have the authority to create exceptions to these regulations.[53]

IV. Conclusion

The Division met its burden and proved, by a preponderance of the evidence, that Mr. N does not currently require dedicated one-on-one staffing 24 hours per day in order to avoid

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[51] It is important to note that whether Mr. N is likely to be institutionalized for lack of dedicated, 24-hour-per-day, one-on-one care, is a separate issue from whether Mr. N is likely to be institutionalized if The No Name no longer receives the acuity rate payment to help pay for his care. The former question is the legal issue presented for resolution in this case. The later question is a separate economic issue involving whether ALFs can provide adequate care, and still earn a reasonable profit, based on the Medicaid rate structure currently in effect. The later question is an issue between ALFs and the Department of Health and Social Services which cannot be resolved in the Fair Hearing context. Medicaid payment rates are established by the Department's Office of Rate Review (ORR) in accordance with 7 AAC 145.005 - 7 AAC 145.739. Additional information on Medicaid rate-setting is available on ORR's website at http://dhss.alaska.gov/Commissioner/Pages/RateReview/default.aspx.

[52] "Administrative agencies are bound by their regulations just as the public is bound by them." *Burke v. Houston NANA, L.L.C.*, 222 P.3d 851, 868 – 869 (Alaska 2010).

[53] *See* 7 AAC 49.170 (limits of the hearing authority).

institutionalization. The Division was therefore correct when it denied that portion of Mr. N's proposed plan of care renewal which requested the acuity rate.[54]

DATED this 20th day of June, 2014.

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 2nd day of July, 2014.

By: *Signed*
Name: Jared C. Kosin, J.D., M.B.A.
Title: Executive Director
Agency: Office of Rate Review, DHSS

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

[54] Mr. N may re-apply for the acuity rate at any time should his condition deteriorate in the future.