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

In the Matter of	)	
	)	
K E	)	OAH No. 16-0117-MDS
	)	

DECISION ON REMAND

I. Introduction

K E is an acutely disabled adult who receives Medicaid Home and Community-Based Waiver program ("Waiver") services. He lives in a group home. As part of his Waiver services, the Department of Health and Social Services, Division of Senior and Disabilities Services ("Division") approved him for an Acuity Add-On rate (Acuity rate), which is additional funding for him to receive dedicated 24 hour care. The Acuity rate was only approved for a limited time. It expired and Mr. E asked that his Waiver service plan be amended to add the Acuity rate back into the plan. The Division denied that request. Mr. E requested a hearing, which was held on April 14, 2016.

A Proposed Decision was issued overturning the denial of the request extension of the Acuity rate and the Division filed a proposal for action. The final decision maker ordered that the Administrative Law Judge:

> Make additional findings <u>in response to the Division's proposal for action on the provision and need for 24/7 one-on-one care, specifically in all environments in which the recipient functions, given any improvements in his condition since acuity was first granted.</u>

On remand the record has been reviewed and these findings have been made. However, evidence still shows that Mr. E cannot transfer safely or ambulate safely, even when using a walker, on his own. When unsupervised, he is at risk for falls, which places him at risk for substantial injury. However, he does not recognize that fact and tries to transfer and ambulate on his own. His group home has tried several different measures to alert staff if he tries to move on his own. Those protective measures only worked for a short while before he learned to circumvent them. As a result, Mr. E requires continuous one-on-one supervision and monitoring to prevent him from transferring and ambulating unassisted. While the evidence presented at the hearing was primarily focused on Mr. E's need for one-on-one care while he was sleeping, a review of the record on remand shows that Mr. E's need for 24/7 one-on-one care continued through May 22, 2016. More specifically, Mr. E needs for 24/7 one-on-one are primarily due to his tendency to try to get up by himself during the night, and his tendency to try to make transfers and ambulate by himself during the day, which puts him at

unreasonable risk of injury and death. Consequently, the Division's denial of his request for an Acuity rate is REVERSED.

II. Facts

Mr. E is a severely intellectually and physically disabled man in his late 40s who lives in a group home. He is profoundly deaf and has cerebral palsy. He was physically active and able to participate in the community, including working. In the summer of 2014, he began experiencing what appeared to be minor seizures. This escalated into falls, limping, and incontinence. His condition continued to worsen and he became wheelchair bound in September 2015. [1]

Mr. E applied for an Acuity rate on September 23, 2015, based upon a need for 24 hour a day supervision to prevent him from attempting to move on his own and injuring himself.[2] Mr. E's primary care physician is Dr. T. She wrote a letter on September 17, 2015, supporting his request.[3] While Mr. E's request was pending, he was found to have cervical spondylosis, for which surgery would be required. He had that surgery on October 27, 2015 and returned home from the hospital on November 18, 2015.[4]

Mr. E's request for an Acuity rate was approved on October 28, 2015, retroactive to September 13, 2015. The approval was for a limited amount of time, 13 weeks.[5] In January 2016, Mr. E requested approval for the Acuity rate to continue until May 22, 2016, the end of his then current plan year.[6] The request reads, in part:

> Without constant, eyes-on, [Mr. E] will attempt to walk or get out of his chair or bed. He still requires someone with him when he uses the walker or transfers from bed, chair or toilet. Staff must be available to K at all times of day and night in order to "spot" his movements and provide physical assistance when necessary to ensure his safety.[7]

This letter shows that Mr. E attempts to make dangerous transfers by himself during the day as well as at night, and that Staff must be watching Mr. E at all times of day and night in order to prevent these attempts to self-transfer and provide physical assistance when necessary to ensure his safety.

Mr. E's primary care physician, Dr. T, and his physical therapist both provided letters in support of the request. Those letters were both dated in December 2015 and opined that Mr. E required 24

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1 Ex. F, pp. 4 – 6.
2 Ex. F, pp. 4 – 6, 8.
3 Ex. F, p. 19.
4 Ex. E, p. 3.
5 Ex. F, pp. 1 – 3.
6 Ex. E, pp. 1 – 3.
7 Ex. E, p. 3.

hour dedicated care to avoid falls. The physician stated that Mr. E had "significant right sided weakness" after his cervical spine surgery, that he was "at very high risk of falling," and that she anticipated he "would require the constant awake caregiver support for another 2 – 3 months as he continues to recover from surgery."[8] The physical therapist stated that Mr. E "does not have the judgment or understanding to make safe choices about his mobility."[9] There is no implication in this letter that this lack of judgment or understanding is limited to the hours when Mr. E is in bed.

The Division denied Mr. E's request for a continued Acuity rate on February 4, 2016.[10] After that denial, Mr. E had surgery for colon cancer in late February 2016. This was abdominal surgery where a portion of the colon was removed. Mr. E's physician, his surgeon, and the hospital case manager all stated that Mr. E required a dedicated caregiver.[11]

Dr. T testified that Mr. E continued to need a dedicated caregiver, because he was not able to walk independently. Her concern is that he might fall, injuring his spine, which could result in paralysis or death. Ms. G is the administrator for the two-person group home where Mr. E resides. She testified that it is unsafe for Mr. E to transfer or ambulate independently. She stated that Mr. E tries to get up by himself, especially at night; his home has tried some alarms to alert caregivers; he has circumvented those; his home has tried checking on him four times an hour, and he managed to get up by himself. She testified that in order to provide for his safety, Mr. E required an awake caregiver. Q E, Mr. E's father, testified about his observations of Mr. E's being a fall risk if he wasn't provided assistance with transfers and ambulation. Dr. T, Ms. G, and Q E were each familiar with Mr. E's care needs and were credible, knowledgeable witnesses.

On remand, a review of Dr. T's testimony shows that she confirmed that her recommendation that Mr. E's need for 24/7 one-on-one care continued through the date of the hearing. Dr. T acknowledged that although Mr. E's condition changed between September and December of 2015, she was still recommending 24-hour supervision. Dr. T explained that previously in September 2015, when she recommended 24-hour supervision was in-part because she was concerned that Mr. E might be having seizures and had several falls. [12]

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8 Ex. E, p. 21.
9 Ex. E, p. 22.
10 Ex. D.
11 No Name Regional Hospital letter dated February 26, 2016; No Name Surgery & Specialty Clinic letter dated March 2, 2016; Dr. T letter dated February 16, 2016.
12 Recording of Hearing-Testimony of Dr. T.

Dr. T testified that when she saw him in December 2015, Mr. E had undergone spine surgery to resolve a problem that was causing the significant weakness on his right side, and he was still recovering from that surgery. When she saw him in December he had recovered from the surgery somewhat, but he was not yet strong enough to move independently. Dr. T was worried at that at that time that Mr. E would feel strong enough to try to get up and ambulate independently, but he was not strong enough to do that safely without supervision, so she recommended 24-hour supervision in her December 2015 letter. Dr. T confirmed in her testimony that this recommendation would continue for as long as Mr. E was unable to safely ambulate independently without supervision. Dr. T testified that based on her understanding of Mr. E's physical condition at the time of the hearing was that it was not safe for him to independently ambulate. [13]

Dr. T testified that because of the surgery to his cervical spine in October of 2015, Mr. E continues to be at an increased risk of serious harm, including paralysis or death if he falls. Dr. T clarified that her recommendation for ongoing 24/7 one-on-one care was primarily based on this safety concern. Dr. T testified that but for the 24/7 one-on-one care at the group home that she recommended until he can safely ambulate independently, the only way that Mr. E would receive an adequate level of care would be for him to be in a nursing home. [14]

Dr. T testified that Mr. E is hearing impaired, has cerebral palsy, which limits his ability to walk and use his upper extremities. He has moderate mental retardation. He can read some, but interacts with caregivers primarily by them using sign-language. He can sign back some things. Dr. T does not anticipate that Mr. E will ever be able to live independently. [15]

Dr. T explained that before the spine surgery Mr. E seemed to accept that he needed to be in a wheel chair, and was compliant with not trying to ambulate independently, because he was so weak, and realized how weak he was. After the surgery, and physical therapy, he has become stronger, but he still is not strong enough yet to safely ambulate independently, but he does not realize this. Dr. T is very concerned about him getting out of bed by himself. [16]

Dr. T explained that Mr. E did have a set-back after his abdominal surgery in February 22, 2016, and was not as strong as he was before that surgery, but not as bad as the set-back after his spine surgery. Dr. T explained that she thinks Mr. E has improved since the abdominal surgery, but he was

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13 Recording of Hearing-Testimony of Dr. T.
14 Recording of Hearing-Testimony of Dr. T.
15 Recording of Hearing-Testimony of Dr. T.
16 Recording of Hearing-Testimony of Dr. T.

not yet at the point that he could safely ambulate independently at the time of the hearing. Dr. T testified that she reviewed the surgery, post-surgery and physical therapy records since she saw him in December of 2015 and that they are consistent with her recommendation for continued 24/7 one-on-one care.[17]

On cross examination, Dr. T explained although in her December letter she had estimated that Mr. E would need 24/7 one-on-one care for another two months, at that time, they had not decided when they would schedule his abdominal surgery, which was scheduled after the letter and caused a set-back in his strength, which had not been accounted for in the two-month estimate. Also, not accounted for in the two-month estimate was the slower than anticipated rate that Mr. E has been taking to recover to his base-line from the spine surgery. [18]

III. Discussion

The Medicaid program has a number of coverage categories. One of those coverage categories is the Waiver program.[19] The Medicaid program pays for specified individual services to Waiver recipients. The Division must approve each specific service as part of the Waiver recipient's plan of care.[20] A Waiver recipient who receives group home habilitation services may receive an Acuity rate, which is paid to the provider.[21] In order to qualify for the Acuity rate, a recipient must need "direct one-to-one support from direct care workers whose time is dedicated solely to providing services . . . to that one recipient 24 hours per day, seven days per week."[22]

As noted previously, Mr. E was provided the Acuity rate for a limited time period. That Acuity rate expired. The credible testimony of Mr. E's physician and two persons who provide care for him, his father and Ms. G, demonstrate that he continues to be unable safely transfer or ambulate independently. His physical therapist stated he needed assistance. Mr. E does not recognize the fact he cannot transfer or ambulate independently. Corrective measures such as alarms and frequent checks on him have not been successful. Consequently, it is more likely true than not true that he needs continual one-on-one supervision, so that assistance with transfers and ambulation is immediately available when he needs it. Because Mr. E resides in a two-person group home, it is not always possible to provide him with that continuous observation and assistance without him having a

17 Recording of Hearing-Testimony of Dr. T.
18 Recording of Hearing-Testimony of Dr. T.
19 7 AAC 100.002(d)(8); 7 AAC 100.502(d).
20 7 AAC 130.217.
21 7 AAC 130.267.
22 7 AAC 130.267(b)(2).

dedicated attendant. As a consequence, Mr. E has shown, by a preponderance, of the evidence that his request for a continued Acuity rate should be granted.[23]

The sources of the unreasonable risk to Mr. E without the 24/7 one-on-one care recommended by Dr. T are threefold. First, until he recovers enough to ambulate independently, he is at increased risk of falling. Second, if he does fall, his recent surgery puts him at increased risk of serious injury or death. Third, he is not compliant with directions not to try to ambulate independently.

It appears that the last of these factors is the source of most of the controversy in this case. Mr. E care providers' attempts to develop alternatives to 24/7 one-on-one care to deal with his inability to comply with instructions not to try to ambulate independently such as alarms that would allow less than one-on-one awake supervision had so far been unsuccessful because Mr. E finds ways to circumvent them. The Division has misread the notes about these attempts as being indicative that Mr. E has not been getting 24/7 one-on-one care while these methods have been tried. The evidence in the record, however, does not show this. The evidence in the record shows that Mr. E care providers have been making diligent efforts to try to develop strategies to obviate the need to continue 24/7 one-on-one care while continuing to provide that service.

In part because these methods such as alarms on the bed were aimed at dealing with Mr. E frequently trying to get out of bed by himself, there was not as much testimony about the need to have constant supervision while he is awake, however, there was testimony about concern that Mr. E will try to ambulate by himself when he is awake, now that he feels stronger. The evidence in the record shows that Mr. E needs constant supervision when he is in bed because he will try to get out of bed and try to ambulate independently. He needs constant supervision when he is in the wheel chair because he will try to get up and ambulate independently. He needs supervision when he is trying to walk because he cannot safely ambulate independently. In short, the evidence shows that he needs constant awake-supervision in all environments in which he functions.

While the evidence at the hearing showed that the original prognosis was that Mr. E would only need constant awake supervision for two-months, and he did show some improvement after his spine surgery, the evidence also shows that there were unanticipated delays in his progress toward safe independent ambulation due to a set-back in strength after his abdominal surgery in late February of 2016, and generally slower than anticipated progress and recovery from his spine surgery.

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[23] Mr. E argued that his condition had not "materially improved" and as a result, his Acuity rate had to be continued. It is not necessary to address this argument inasmuch as this decision finds in his favor.

The preponderance of the evidence in the record shows the need for continued 24/7 one-on-one care through May 22, 2016.

IV. Conclusion

The Division's decision to deny Mr. E's request for an Acuity rate from January 8, 2016 through May 22, 2016 is reversed.

DATED this 31st day of October, 2016.

Signed
Mark T. Handley
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 9th day of November, 2016.

By: *Signed*
Signature
Douglas Jones
Name
Medicaid Program Integrity Manager
Title

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