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

In the Matter of	)	
	)	
C U	)	OAH No. 16-0366-MDS
	)	Agency No.

DECISION

I. Introduction

C U receives Medicaid Home and Community-Based Waiver program ("Waiver") services for individuals with intellectual and developmental disabilities. The Department of Health and Social Services, Division of Senior and Disabilities Services ("Division") previously approved him to receive an Acuity Add-On rate. An Acuity Add-On rate is available to applicants needing dedicated one-on-one staffing 24 hours per day. When Mr. U applied to renew his Waiver Plan of Care, the Division notified him that it did not approve the Acuity Add-On rate.[1] Mr. N U, C's father and guardian, requested a hearing to challenge the denial.[2]

The evidence shows that although Mr. U requires a high level of care, he does not require the dedicated, one-on-one, 24-hour-per day staffing necessary to receive an Acuity Add-On rate. The Division's decision terminating his Acuity Add-on rate is affirmed.

However, the evidence in the record also indicates that, once the services funded by Mr. U's Acuity Add-On rate are removed, Mr. U will be at risk of institutionalization because the level of support provided by his remaining waiver services is insufficient for his needs. Accordingly, the Division may not remove the services funded by the Acuity Add-On rate until Mr. U submits a proposed Plan of Care amendment, the Division acts on the amendment request, and all associated administrative appeal rights are exhausted. Mr. U has 30 days from the date this decision becomes final to submit a proposed Plan of Care amendment to the Division.

II. Facts

Mr. U is a severely disabled 30 year-old man who lives in a group home. The group home where Mr. U lives has three other severely disabled people in it.[3] Two staff members work at the home at all times.[4] One of the staff members is assigned to work only with Mr. U.[5] Mr. U's

---

1 Ex. D, pp. 1 - 2.
2 Ex. C.
3 J testimony.
4 Ex. L, p. 27.
5 F testimony.

family visits him daily for several hours and provide support.[6] Mr. U also receives nursing oversight support.[7]

Mr. U has extensive care needs. His diagnoses include cerebral palsy, autism, profound intellectual disability, dysphagia, and seizure disorder.[8] Mr. U experienced one grand mal seizure in August 2015 requiring an emergency room visit.[9] He has daily petit mal seizures. During a petit mal seizure, Mr. U gazes off and makes clicking sounds. He usually falls asleep afterwards.[10] Staff monitors Mr. U for petit mal seizures, but no post-seizure intervention is documented.

Mr. U also displays significant behavioral problems including aggression and irritability.[11] He bangs his head against things and has a helmet available for protection. He grabs, scratches, kicks, pokes, spits, and pulls staff members' and others' hair, often on a daily basis. These aggressive actions are often unpredictable. Staff must be vigilant, keeping Mr. U a safe distance from others both while in his home and out in public. Medication is available if Mr. U's irritability becomes unmanageable, but it has not been needed for some time.[12]

Mr. U is dependent upon others for his activities of daily living.[13] He eats pureed foods, supplemented by gastronomy tube (g-tube) delivered nutrition. Mr. U tugs at his g-tube, but has not pulled it out since 2014. Mr. U requires extensive time to eat and must be monitored by staff.[14] Meal preparation and delivery, including snacks and supplements, may take up to six hours per day.[15]

Mr. U is incontinent. Changing Mr. U's adult diaper takes between 5 and 20 minutes, and requires two staff members when Mr. U is agitated.[16] Two staff members are also needed to bathe Mr. U and to assist him with walking exercises.

Mr. U has some difficulty sleeping, but is generally in bed at least 8 hours per night, and takes naps during the day.[17] Mr. U is to be checked for incontinence every two hours and visually

---

6 Ex. E, p. 8.
7 Ex. E, pp. 2, 37.
8 Ex. E, 4, Ex. 2.
9 Ex. E, 5.
10 J testimony.
11 Notes and testimony indicate that Mr. U's seemingly aggressive behaviors may, at times, be indications of excitement or playfulness.
12 Ex. E, pp. 37, 62.
13 Ex. F, pp. 4, 6, 8.
14 Ex. E, p. 11.
15 N U letter to Fair Hearings, April 26, 2016.
16 Ex. E, pp.57-60; N U's letter states that changing C U's Depends can take 20-30 minutes. Care logs indicate it takes between 5 – 15 minutes.

observed every 15 - 20 minutes during the nighttime hours.[18] His care logs document that he was checked every two hours during the night, but do not clearly document four observations per hour.[19] His Plan of Care states that Mr. U needs "constant monitoring" at night so he does not bang his head.[20] Mr. U's recent medical records do not indicate any new medical or behavioral concerns.[21]

Mr. U receives Medicaid Waiver services under the intellectual and developmental disability (IDD) category. The Division approved an Acuity Add-On rate in 2011.[22] Mr. U applied to renew his Waiver Plan of Care, including the Acuity Add-On rate, for the period from January 2, 2016 through January 1, 2017.[23] The Division denied Mr. U's request for a continued Acuity Add-On rate, but approved the remainder of his Waiver Plan of Care renewal application. The Division approved up to 15 hours per week of one-on-one Day Habilitation services, which are not available to those approved for the Acuity Add-On rate.[24]

In its denial letter, the Division stated it did not find sufficient justification for continued Acuity Add-On payments.[25] The Division's notice states:

> He has had one documented seizure during the past year. C sleeps well most nights and naps during the day. C has not engaged in self-injurious or assaultive behaviors that required that a CIR be submitted. Further, service notes indicate that a staff member is not with C on a one-with-one basis 24 hours a day. The totality of the information provided indicates to the Division that C's concerning behaviors and medical needs are significantly less in amount, intensity, and duration then when a [sic] Acuity Add-On was first approved.[26]

Mr. U requested a fair hearing on April 8, 2016. The parties attempted, but were unsuccessful, in resolving the matter before hearing. Mr. U's hearing was held on September 11, 2012. Mr. N U, Care Coordinator P X, Residential Program Director L J, and B F, residential psychiatric supervisor for No Name Agency, testified on Mr. U's behalf. Victoria Cobo, Division

---

17 Mr. U's Plan of Care indicates much more challenging sleep patterns than do his care logs and medical records. *Compare*, Ex. E, 13; Ex. E, pp. 56 – 60; Ex. 2, March 24, September 8, 2015, medical records noting Mr. U is doing well and sleeping better.

18 N U's testimony and letter.

19 Ex. E, pp. 56-60. C U's care logs do not indicate observation every 15 minutes. Instead, they note "checked" over a two hour period. Ex. 8, T-logs, state that Mr. U is checked every two hours.

20 Ex. E. p. 13.

21 2014-2016 medical records.

22 Ex. E, p. 1; Ex. F.

23 Ex. E, p.2.

24 Ex. D; 7 AAC 130.265(g)(2).

25 Ex. D, p. 2, Revised denial letter.

26 Ex. D, p. 2. CIR stands for Critical Incident Report.

fair hearing representative, presented the Division's position. Glenda Aasland and Andy Sandusky testified for the Division.

The record remained open until June 3, 2016. Ms. J submitted documentation, known as T-logs, from Mr. U's caretakers. The Division filed a response. Ms. J requested an extension to reply to the Division. The extension was granted, but no reply was filed. The parties were also asked to submit briefing on the type and amount of additional supports Mr. U might need if the Division's Acuity Add-On denial was affirmed. The Division submitted briefing which explained available supports and limitations, but did not make specific recommendations. Mr. U did not submit briefing on the issue.

III. Discussion

A. Waiver program and Acuity Add-On rate overview

The Medicaid program has a number of coverage categories. One of those coverage categories is the Waiver program.[27] The Waiver program provides supports to individuals who would otherwise be institutionalized due to physical or intellectual disabilities.[28] The Medicaid program pays for specified individual services to Waiver recipients.[29] The Division must approve each specific service as part of the Waiver recipient's plan of care.[30] The approved service must be sufficient in amount, duration, and scope to meet the needs of the recipient and prevent institutionalization.[31] A Waiver recipient's plan of care is subject to review on a yearly basis.[32]

A Waiver recipient who is approved to receive group home habilitation services may receive an Acuity Add-On rate, which is paid to the provider.[33] The Acuity Add-On rate is available only to a recipient who receives residential supported-living services or group-home habilitation services, and whose physical condition or behavior require one-to-one support from dedicated direct care workers 24 hours per day, seven days per week, in all environments.[34] The Acuity Add-On rate request must be supported by documentation establishing its need.[35]

As noted previously, Mr. U was provided the Acuity Add-On rate since 2011. The issue is whether Mr. U should continue to receive the Acuity Add-On rate. Mr. U argues that he should

---

27 7 AAC 130.200.
28 7 AAC 130.205.
29 7 AAC 130.205(a).
30 7 AAC 130.217.
31 7 AAC 130.217.
32 7 AAC 130.217.
33 7 AAC 130.267; 7 AAC 145.520(m).
34 7 AAC 130.267.
35 7 AAC 130.267.

continue to receive the Acuity Add-On rate because he requires dedicated one-on-one staffing 24 hours per day. His parents, care providers, and psychiatrist also support one-on-one staffing.[36]

Because this case involves the termination of a specific benefit, the Division has the burden of proof by a preponderance of the evidence.[37]

B. Mr. U does not require an around-the-clock, dedicated staff person.

Acuity Add-On rates can be approved for severe medical issues, behavioral issues, or a combination of both. Approximately 12 people in the State of Alaska currently receive the Acuity Add-On rate.[38] This low number indicates the high level of care needed for Acuity rate approval. It is a level that is much higher than the already high level of care needed to qualify for Waiver.

Mr. U was initially approved for the Acuity rate "due to self-injurious behaviors, physical aggression towards staff members and others, frequent and sometimes alarming seizure activity and disrupted sleep patterns."[39] Each of these bases will be examined in turn.

First, documentation indicates that Mr. U has sleep issues, but is in bed for eight or more hours each night. He also naps approximately two hours per day on most days. Staff observes Mr. U when he sleeps, but no interventions are generally needed. Overall, Mr. U's sleeping patterns are improved. Staff reported this to Mr. U's medical provider, and Mr. U's T-logs note only two nights without sleep.[40] Care calendars, T-logs, and reports to providers indicate that Mr. U sleeps through most of the night.

At hearing, Mr. N U testified that staff checks on Mr. U every fifteen minutes and check his Depends every two hours.[41] Ms. F testified that Mr. U requires these checks for health and safety. Because Mr. U has a seizure disorder, regular observation is necessary. However, observation every fifteen minutes does not meet the strict requirements of 7 AAC 130.267, which requires a documented need for dedicated one-on-one staffing. Further, a staff person can visually observe Mr. U and others residents during the same "round" every quarter hour. This also does not satisfy the "dedicated" and "one-on-one" staffing requirements necessary to receive the Acuity rate.

---

36 Ex. 1; Ex. 7, letter from N U; Ex. E, pp. 50-52, letter from No Name Agency; testimony.

37 7 AAC 49.135.

38 Aaslund testimony; Sandusky testimony.

39 Ex. D, p. 2.

40 Ex. 2, medical records, March 24, 2015; September 8, 2015; Ex. 8, T-logs, June 9, 2015, August 15, 2015.

41 Mr. U's Care Calendars and T-logs do not document observation every 15 minutes.

The Executive Director of No Name Agency, which runs Mr. U's group home, asserts that Mr. U requires a dedicated staff person at night in case of a medical emergency requiring transport.[42] This argument is unpersuasive. Waiver recipients, by definition, are vulnerable. They are often aged, disabled, or medically fragile. An elderly Waiver client living in an Assisted Living Home might attempt to wander off during the night, or could suffer cardiac arrest. A child with complex medical needs might develop complications requiring immediate transport at any time. A recipient might need medical assistance with breathing apparatus, or like Mr. U, a feeding tube. Emergency medical services, family, on-call staff, or a home's administrator can be used for these irregular yet foreseeable occurrences. A potential need for medical transport does not justify Acuity Add-On rate approval.

Next, Mr. U's grand mal seizure activity is currently well-controlled with medication. Although Mr. U experiences multiple petit mal seizures each day, no follow up or intervention is documented. Both Mr. U's sleep patterns and his seizure disorder have improved, and currently do not meet the 24/7 sole care provider requirement.

Mr. U's behaviors, on the other hand, have not improved. Mr. U continues to exhibit regular aggressive behaviors, both towards himself and others. The Division argues that the documentation required to support Acuity Add-On approval, due to behavioral problems, was insufficient. It pointed to the fact that no Critical Incident Reports were filed regarding Mr. U during the previous year. However, Ms. J testified credibly that Senior and Disabilities employees informed her that if the Plan of Care documented regularly occurring behavioral issues, staff need not file Critical Incident Reports unless the incident required medical attention.[43] Mr. U's Plan of Care does document behavioral issues, and testimony corroborated regular hitting, scratching, poking, etc.

The documentation originally submitted with the Plan of Care contained evidence of only intermittent behavioral concerns.[44] Ms. J and Ms. F opined that goal tracking information submitted to the Division did not paint as accurate a picture as the T-logs. Additionally, they testified that because staff members are trained to deal with Mr. U's aggression, and are used to providing his care, they underreport its severity. All who testified on Mr. U's behalf stressed that his care needs are extensive, more so than the home's other residents.

---

[42] *See* No Name Agency letter, Feb. 12, 2016, summarizing care needs and requesting continued one-on-one staffing.

[43] The Division could neither confirm nor deny this direction from other Division staff. Because of this, the lack of Critical Incident Report filings was not given any weight.

[44] Ex. E, pp. 62-119.

While this may be the case, his behavioral issues are not continuous. There are many notes that detail Mr. U having a good day or spending time watching television – regular events, like naps and sleeping, that do not require one-on-one dedicated staff.

All evidence, including T-logs and testimony, were carefully considered. The availability of family supports was also considered.[45] The record does not support a finding that Mr. U's care needs currently require one-on-one staffing at all times, in all environments, as required for the Acuity Add-On Rate.

C. Mr. U requires more than 15 hours per week of Day Habilitation Services.

Mr. U requires one-on-one staffing when he goes into the community, when he is eating, or being transferred. He requires two-to-one staffing for showers, exercise, and for other activities when he is particularly agitated. Because of his care needs, Mr. U requires dedicated staff much of the day. The Division approved up to 15 hours per week of Day Habilitation services. That is just over two hours per day. This is not enough to offset the increased risk of institutionalization and care giver or recipient harm resulting from removal of the Acuity Add-On rate. Therefore, the Division must approve additional services before removing the Acuity Add-On rate from Mr. U's Plan of Care.

Mr. U did not respond to the request for briefing concerning the appropriate types and amounts of waiver services needed in the absence of the Acuity Add-On. The Division responded that Supported Employment or additional Day Habilitation services may be appropriate. Supported Employment was not explored at hearing, but may be an inappropriate alternative given Mr. U's aggressive and unpredictable behaviors. Day Habilitation is required to occur outside the home and is capped at 15 hours per week, unless the Division finds that exceptions to these rules exist.[46] The record supports a finding that Mr. U requires significantly more Day Habilitation services to live safely in the group home and avoid institutionalization. The record also supports a finding that some Day Habilitation services should be provided in the home.

IV. Conclusion

Mr. U no longer satisfies the requirements for receiving an Acuity Add-On rate. As a result, the Division's decision to deny that portion of his 2016-2017 Medicaid Waiver plan of care is affirmed. However, the Division may not remove the Acuity Add-On rate until Mr. U submits

[45] Mrs. U is no longer able to assist with his care, but does visit Mr. U. Her husband, Mr. N U, visits and assists as his work schedule allows. The record contains evidence that his siblings visit, but does not state whether they assist in his care. The Plan of Care indicates that his family visits each day and provides access to some activities outside the home.

[46] 7 AAC 130.260.

a Plan of Care amendment, the Division acts on the amendment request, and associated administrative appeal rights are exhausted. Mr. U has 30 days after the final decision in this matter to submit a Plan of Care amendment.[47] If Mr. U does not submit a Plan of Care amendment within 30 days after issuance of a final decision in this matter, the Division may remove his Acuity Add-On rate.

DATED: July 5, 2016.

By: *Signed*
Bride Seifert
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 28th day of July, 2016.

By: *Signed*
Name: Bride Seifert
Title/Division: ALJ/OAH

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

[47] The final decision occurs after the proposal for action deadlines and is made by the Commissioner of Health and Social Services, or someone she designates to make the final decision for her. If no proposal for action is filed, the ALJ may adopt the proposed decision as final.