Non-Adoption Options

D. The undersigned, in accordance with AS 44.64.060(e)(5), rejects, modifies or amends the interpretation or application of a statute or regulation in the decision as follows and for these reasons:

I. Introduction

T W received Medicaid Home and Community-Based Waiver services for individuals with intellectual and developmental disabilities. A Plan of Care renewal was submitted to the Department of Health and Social Services, Division of Senior and Disability Services, which contained a request for the Acuity Add-On rate. The Division of Senior and Disability Services did not approve the Acuity Add-On rate. The Division's denial of the Acuity Add-On was appealed, and a proposed decision reversing the Division's denial was issued. The regulation covering this service requires specific documentation to be submitted in support of the Acuity Add-On rate. This documentation was not submitted.

II. Discussion

At issue here is the application of 7 AAC 130.267 Acuity payments for qualified recipients. 7 AAC 130.267 provides a list of specific documentation that must be provided by the recipient's care coordinator in order to request Acuity services. It is uncontested that the documentation required to be provided to the division for consideration of the Acuity Add-On rate was not provided as required in regulation.

III. Conclusion

There is a high standard established by regulation for approval of this service. Services may be approved if the department determines it is necessary based on an evaluation of the supporting documentation submitted in accordance with 7 AAC 130.267. The documentation required to be submitted under the regulation is clear, and there is no dispute it was not provided

to the Division for their consideration. Accordingly, the Division's decision to deny the Acuity Add-On rate is upheld.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with AS 44.62.560 and Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 21st day of January, 2017.

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

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

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

In the Matter of	)	
	)	
T W	)	OAH No. 16-0809-MDS
	)	Agency No.

CORRECTED DECISION[1]

I. Introduction

T W receives Medicaid Home and Community-Based Waiver ("Waiver") program services for individuals with intellectual and developmental disabilities. The Department of Health and Social Services, Division of Senior and Disabilities Services 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. W applied to renew his Waiver Plan of Care, the Division notified him that it did not approve the Acuity Add-On rate.[2] K and W W, T's parents and guardians, requested a hearing to challenge the denial.[3]

The evidence shows that although Mr. W's overall health has improved and stabilized, his care needs remain very high. Mr. W still requires the dedicated, one-on-one, 24-hour-per day staffing necessary to receive an Acuity Add-On rate. Therefore, the Division's decision terminating his Acuity Add-On rate is reversed.

II. Facts

Mr. W is a severely disabled 19-year-old man with extensive care needs. He cannot care for himself or provide for his own safety. Mr. W's diagnoses include severe autism, developmental delay, anxiety disorder with agitation and self-abuse, adjustment disorder with anxiety, and bipolar.[4] He is incontinent of urine and feces and suffers from manic episodes.[5]

Mr. W displays significant behavioral problems including aggression and self-injurious behaviors (SIB) - biting, scratching, punching, hitting, and head banging.[6] His SIB are severe and have resulted in wounds and infection. For example, nursing service notes describe Mr. W's injuries as reddened and swollen with "dime size areas of skin missing with abrasions and

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1 The original decision contained a typographical error on page 8. "October" should have read "August."
2 Ex. D1 - 2.
3 Ex. C.
4 Ex. E4; Ex. 2.
5 Ex. E15.
6 Ex. E29; E36 - 40; E S, PA-C Letter; D T testimony.

bruising around the areas of skin missing."[7] Mr. W is a light sleeper, who engages in SIB when awoken.[8] Mr. W wears a helmet with face shield, mittens, and arm protection to lessen the risk of injury.[9] He also has a weighted vest and blanket. Mr. W is able to locomote on his own and can move quickly. Staff must monitor him at all times, so that he does not injure himself or others.[10]

Mr. W lives in a licensed group home in Alaska, where he has been living since August 8, 2015.[11] From 2011 to May 15, 2015, Mr. W lived in an intermediate care facility for individuals with intellectual disability in Idaho.[12] In Idaho, Mr. W received the assistance of two-to-one staffing.[13]

In May 2015, Mr. W returned to Alaska to live in a four person licensed group home. Even with two staff working with him, his transition did not go well. After a manic episode requiring the evacuation of other residents and staff, Mr. W was admitted to No Name Hospital, where he stayed from June 2, 2015, to August 11, 2015.[14]

No Name Agency staff worked closely with No Name Hospital and Mr. W's care providers to create a transition plan for Mr. W's safe return to the community.[15] Mr. W's supports included: two-to-one staffing at all times; tele-medicine; behavioral health appointments with No Name Hospital psychiatrists; in home visits from E S, PA-C; consultations and guidance from Dr. D M and U Q, Ed. D.; and regular in-person support from D T, of the Complex Behavioral Collaborative. Because of his history of sleep disturbance, Dr. Q and PA S recommended using an iPad to monitor Mr. W during the night.[16]

With the transition plan in place, Mr. W moved into his own apartment within the group home. Staff worked with Mr. W on his behaviors and over time, his severe SIB has decreased. Due to this increased stability, No Name Agency reduced Mr. W's staffing plan from two-to-one to one-on-one in January 2016.[17]

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7 C T, RN, nursing notes (February 1, 2016).
8 F F testimony
9 Ex. E27.
10 F testimony.
11 Ex. E28.
12 Ex. E28.
13 N J testimony.
14 Ex. E33; J testimony.
15 Ex. E33 - 34. No Name Agency manages both group homes that Mr. W has lived in since his return from Idaho.
16 S Letter; Q Letter, "Previous attempts by staff to physically check on Mr. W during the night resulted in disturbing his sleep, causing him to remain awake and engage in SIB, occasionally injuring staff."
17 Ex. J.

Because of his high care needs, Mr. W receives Medicaid Waiver services under the intellectual and developmental disability (IDD) category. He also receives nursing oversight.[18] Mr. W applied to renew his Waiver Plan of Care, including the Acuity Add-On rate, for the period from May 15, 2016, through May 14, 2017.[19] The Division denied Mr. W's request for a continued Acuity Add-On rate, but approved the remainder of his Waiver Plan of Care renewal application.[20] The Division's denial letter indicates that perhaps Mr. W would benefit from Day Habilitation or Supported Employment services, which are not available to those approved for the Acuity Add-On rate.[21]

In its denial letter, the Division stated it did not find sufficient justification for continued Acuity Add-On rate payments.[22] The Division's notice states that:

> According to the summary of internal incident reports, it appears that aggression toward others had decreased as he transitioned into his home; however he continues to exhibit self-injurious behaviors . . . . The POC also discusses that every 4 weeks, T will have "manic episodes" where he does not sleep and his self-injurious behaviors; however, the increase in behaviors are not documented on the behavior or sleep logs that were submitted . . . . The service notes demonstrate that T slept 7+ hours for 28 out of the 30 days documented and the sleep logs show a similar pattern. While No Name Agency is reporting staff is available 24 hours, the notes describe that staff monitor him using technology and physically check on him every 2 hours.[23]

Mr. W requested a fair hearing on July 12, 2016.[24] Mr. W's hearing was held on September 27, 2016. Darcie Shaffer presented the Division's position and called Joanna Croxton, IDD waiver reviewer, Summer Wheeler, Health Program Manager II, D D-T, No Name office wavier health program manager, Liza McCafferty, Health Program Manager II, and L C, Health Program Manager II and Mr. W's former care coordinator as witnesses. N J, No Name Agency Residential Program Director and former care coordinator for Mr. W, D T, with the University of Alaska's Center for Human Development, and F F, No Name Agency's executive director, testified on Mr. W's behalf.

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18 Ex. D1; Ex. E72 - 78.
19 Ex. E.
20 Ex. D.
21 Ex. D; 7 AAC 130.265(g)(2).
22 Ex. D.
23 Ex. D.
24 Ex. C2.

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.[25] The Waiver program provides supports to individuals who would otherwise be institutionalized due to physical or intellectual disabilities.[26] The Medicaid program pays for specified individual services to Waiver recipients.[27] The Division must approve each specific service as part of the Waiver recipient's Plan of Care.[28] The approved service must be sufficient in amount, duration, and scope to meet the needs of the recipient and prevent institutionalization.[29] A Waiver recipient's Plan of Care is subject to review on a yearly basis.[30]

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.[31] 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.[32] The Acuity Add-On rate request must be supported by documentation establishing its need.[33]

The Division has approved the Acuity Add-On rate for Mr. W since at least his return to Alaska.[34] The issue is whether Mr. W should continue to receive the Acuity Add-On rate. Mr. W's parents, care providers, and medical providers argue that he should continue to receive the Acuity Add-On rate because he requires dedicated, one-on-one staffing, 24 hours per day.[35]

The Division asserts that Mr. W's care needs, though high, no longer meet the Acuity Add-On rate requirements.[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] Although a close call, the Division did not meet its burden.

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25 7 AAC 130.200.
26 7 AAC 130.205.
27 7 AAC 130.205(a).
28 7 AAC 130.217.
29 7 AAC 130.217.
30 7 AAC 130.217.
31 7 AAC 130.267; 7 AAC 145.520(m).
32 7 AAC 130.267.
33 7 AAC 130.267.
34 D-T testimony. It is not clear when the Division first approved Mr. W for the Acuity Add-On rate.
35 Ex. 1; Ex. 7; S letter; Q letter; J testimony.
36 Ex. D.
37 7 AAC 49.135.

B. Mr. W continues to 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. In order to qualify for the Acuity Add-On rate, a recipient's care needs must be at a higher level than the already high level of care needed to qualify for Waiver. Mr. W's needs continue to meet that threshold.

1. Opinions regarding Mr. W's care needs.

Those individuals most familiar with Mr. W's needs provided persuasive support that he continues to meet the Acuity-Add On requirements. When Mr. W was released from No Name Hospital, Mr. T provided in-person observation and guidance two days per week for several months, at times staying overnight. Mr. T is a consultant for the State of Alaska's Complex Behavioral Collaborative (CBC), providing guidance since the pilot project in 2012.[38] In that time, CBC has served approximately 130 individuals with challenging behavioral issues. Mr. T testified credibly that Mr. W is the lowest functioning individual in the CBC program. Likewise, Mr. Q, a behavioral specialist consulting with No Name Agency for more than 15 years, characterized Mr. W's SIB as "amongst the most extreme and pervasive that I have observed and places him in potentially serious jeopardy."[39]

Mr. T testified to his belief that removal of the Acuity-Add On rate and concomitant level of care would result in Mr. W's decline and institutionalization. PA S averred that anything less than one-on-one care, 24 hours a day, 7 days a week "will likely lead to premature morbidity and mortality."[40] Mr. Q asserts that reducing Mr. W's "staffing ratio at night or any time, would result in jeopardizing his safety and newly improved quality of life and place Mr. W in harm's way."[41]

It appears that Mr. W's overnight care needs are the main point of contention. PA S and Ms. J testified that attempts to have staff remain in his room overnight resulted in less sleep, and an increase in aggressive and self-injurious behaviors. In order to avoid this outcome, staff monitors Mr. W via an iPad and only physically checks him for incontinence every two hours. PA S, Mr. W's primary medical provider, states that Mr. W requires continuous monitoring so that he does not injure himself in the night.[42]

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[38] T testimony; *see http://dhss.alaska.gov/dbh/Pages/ComplexBehavior/Default.aspx.*
[39] Q letter.
[40] S letter.
[41] Q letter.
[42] S letter.

The Division agrees that Mr. W has high care needs, but asserts that he does not need continuous, dedicated, around the clock care.

2. Bases for denial.

The Division asserts three bases for its denial. The first is lack of supporting documentation; second is its interpretation of direct, dedicated, care; and third is the Division's contention that Mr. W's needs can be met through regular supported living services.

i. *Lack of documentation*

The Division argues that the documentation required to support Acuity Add-On rate approval, due to behavioral problems, was insufficient. This assertion is accurate. The Division determines whether to approve the Acuity Add-On rate based on its evaluation of supporting documents accompanying the rate request.[43] As the Division stated, "if it wasn't documented, it did not happen."[44]

Service notes and sleep logs indicate that Mr. W slept at least seven hours for 28 of 30 nights in May 2016.[45] Notes do not indicate continuous observation via the iPad and often fail to note physical checks for incontinence every two hours. The Division also points to a lack of critical incident reports as evidence that Mr. W's care needs are such that he no longer meets the Acuity Add-On rate requirements. Further, when the Division conducted an on-site visit in April 2016, the staff member working with Mr. W took several minutes to locate the iPad, which was out of battery power when found.[46]

Mr. W's witnesses, on the other hand, counter that the Plan of Care documents Mr. W's continued high needs. Ms. J argues that Division staff instructed No Name Agency that critical incident reports are not required if the behaviors are included in the Plan of Care and no follow-up medical care is needed. Furthermore, Ms. J and Mr. T directly observed Mr. W, his care needs, and his staffing plan.

This is a close question. Regulation requires appropriate documentation to support Acuity Add-On rate approval and No Name Agency did not provide it. On the other hand, Mr. W's history, his Plan of Care, letters from care providers, and credible testimony from Ms. J and Mr. T establish that Mr. W still requires dedicated one-to-one staffing 24 hours per day to maintain his health and avoid institutionalization. Therefore, under the specific facts of this case,

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43 7 AAC 130.267(b)(2).
44 Shaffer oral argument.
45 Ex. G.
46 D-T testimony.

No Name Agency's failure to provide adequate documentation does not preclude continued Acuity Add-On rate approval.

ii. *Direct, dedicated care*

The Division also argues that Acuity Add-On rate approval requires staff to be in the same room, next to, or in direct contact with the recipient.[47] In-room overnight staffing does not work for Mr. W. Instead, this compounds his already delicate health status. It was precisely because of these concerns that his medical and other care providers ordered electronic monitoring.

The Division's interpretation is not supported by regulation language. Acuity Add-On rate approval is designed for individuals who, due to physical condition or behavior, 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, in all environments in which the recipient functions."[48]

Two prior OAH decisions, *In re S H* and *In re LC* clarify this regulation. "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."[49] S H's overnight care was intermittent. LC did not receive one-to-one dedicated care at night or during the day.[50] Additionally, LC did not have a history of institutionalization.[51] Another, recent OAH decision, *In re C U,* upheld the Division's denial of the Acuity Add-On rate for an individual with high care needs similar to Mr. W.[52] There, the record established that care providers physically checked C U every two hours and visually monitored him every 15 minutes.

In contrast, Mr. W's care plan provides for constant visual monitoring, at times through electronic means, and a dedicated staff person in his unit that can respond immediately to issues. The testimony and documentation also establish that Mr. W has a staff person *dedicated solely to providing him* services 24 hours a day in all environments. Moreover, Mr. W was institutionalized as recently as August 2015, and up until the end of January 2016, he had been

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47 Wheeler testimony.
48 7 AAC 130.267(b)(2).
49 OAH No. 12-0616-MDS (Comm'r Health & Soc. Services, November 2012); OAH No. 12-0645-MDS (Comm'r of Health & Soc. Services, November 2012).
50 *In re LC,* at 11 - 12.
51 *In re LC,* at 13.
52 OAH No. 16-0366-MDS (Comm'r Health & Soc. Services, July 2016).

receiving two-to-one direct care. [53] The recency of Mr. W's institutionalization and two-to-one staffing plan support continued approval for the Acuity Add-On rate, for the time being.

iii. *Other waiver services*

In its denial letter and at hearing, the Division opined that all group home residents require around-the-clock care and that Mr. W's needs could be met through the addition of day habilitation services or supported employment. The Division correctly noted that Mr. W enjoys being out in the community. The Division also argued that other waiver services have not been tried and failed.[54]

Ms. F and Ms. J testified about behaviors Mr. W has displayed during previous outings. Ms. F testified that Mr. W will elope, run up to people, and display aggressive behaviors (or inappropriate affectionate behavior). Ms. J witnessed an attempted Day Habilitation outing in Idaho. Ms. J and two staff accompanied Mr. W to a soup kitchen for volunteer work. It took 30 minutes to get Mr. W from the car and into the building because he kept dropping to the ground. Once inside, he threw cans of food, ripped an oxygen mask off a person in the food line, and ran out the door.[55]

There is no doubt that Mr. W is benefiting from his high level of care and that his challenging behaviors are lessening. At this time, however, day habilitation services and supported employment may not be appropriate for Mr. W.

IV. Conclusion

Due to his high level of care, Mr. W is engaging in fewer SIBs and is sleeping better. If his progress continues, it is likely that eventually he will no longer require dedicated, around-the-clock staffing. The record, however, supports a finding that Mr. W's care needs continue to require one-on-one staffing at all times, in all environments, as required for the Acuity Add-On rate. As a result, the Division's decision to deny the Acuity Add-On rate is reversed.

DATED: December 9, 2016.

By: *Signed*
Bride Seifert
Administrative Law Judge

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

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53 The original proposed decision stated "October 2015." The Division's PFA pointed out the typographical error. The typographical error was corrected as allowed under 7 AAC 64.350.

54 C testimony. The Division did not point to a regulation that required failed attempts at a lower level of care in order to continue services. Here, Mr. T testified that without the high level of care provided under the Acuity Add-On rate, Mr. W would likely require institutionalization.

55 J testimony.