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

In the Matter of	)	
	)	
N K	)	OAH No. 16-1358-MDS
	)	Agency No.

DECISION

I. Introduction

N K is a profoundly disabled young woman who receives Medicaid Home and Community Based Waiver program services. Ms. K's Plan of Care has previously included an additional "acuity rate" under 7 AAC 130.267. When Ms. K applied to renew her Plan of Care, the Division of Senior and Disabilities Services denied the request to continue providing the acuity rate. Through her mother and legal guardian, Ms. K appealed. Because the Division has met its burden of proving that Ms. K does not satisfy the very high, very strict regulatory requirements for an acuity rate, its decision is affirmed.

II. Background

The Medicaid program has a number of coverage categories, one of which is the Waiver program.[1] The Waiver program provides supports to individuals who would otherwise be institutionalized due to physical or intellectual disabilities.[2]

The Medicaid program pays for specified individual services to Waiver recipients.[3] The Division of Senior and Disabilities Services must approve each individual service as part of the Waiver recipient's Plan of Care.[4]

Particularly high-needs waiver recipients receiving group home habilitation services may also qualify to receive an additional "acuity rate," which is paid to the provider.[5] Only twelve Medicaid recipients in Alaska currently qualify for this level of care.[6] To qualify for the acuity rate, a recipient receiving group home habilitation services must, "because of the recipient's physical condition or behavior," need "direct one-to-one support from direct care workers whose time is dedicated solely to providing [those] services ... to that one recipient 24 hours per day,

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1 7 AAC 100.002(d)(8); 7 AAC 100.502(d).

2 7 AAC 130.205.

3 7 AAC 130.205(a).

4 7 AAC 130.217.

5 An acuity rate is also available for recipients who receive residential supportive living services under 7 AAC 130.255; for simplicity in light of Ms. K's particular situation, this summary is limited to recipients of group-home habilitation services under 7 AAC 130.265(f).

6 Croxton testimony.

seven days per week."[7] The request for an acuity rate add-on must be supported by documentation establishing the need for this extra level of support.[8]

III. Facts

A. Ms. K's background and medical condition

Ms. K is a profoundly disabled 26-year-old woman whose diagnoses include cerebral palsy, quadriplegia, anoxic brain damage, and a seizure disorder.[9] Ms. K receives waiver services under the Individuals with Intellectual and Developmental Disabilities (IDD) category.[10] She has lived in a group home since 2010; she currently lives with two other severely disabled adults in a group home operated by Facility A.[11] For some if not all of that time, Ms. K's Plan of Care has also contained an acuity rate payment.[12]

It is undisputed that Ms. K requires full assistance in all activities of daily living, and is completely physically dependent on others.[13] Her care routines take significantly longer than those of the home's other two residents.[14] She is unable to take any food, liquids, or medication through her mouth, and receives all her nutrition through a gastronomy tube.[15]

Ms. K also has a tracheostomy tube in place to maintain her airway.[16] Because of her tracheostomy tube, Ms. K must have her oral secretions suctioned away from her mouth and/or from her tracheostomy site by a caregiver.[17] Ms. K benefits from having a strong cough that enables her to clear some secretions on her own.[18] But depending on the circumstances – including whether her seasonal allergies are affecting her, whether she has a cold, et cetera – she sometimes requires very frequent suctioning.[19]

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[7] 7 AAC 130.267(b)(2).

[8] 7 AAC 130.267.

[9] Ex. E, pp. 3, 92.

[10] Ex. E, p. 1.

[11] A testimony; Ex. E, pp. 12-13, 21.

[12] The evidentiary record does not contain documentation related to the initial decision to provide an acuity payment, nor does it indicate when the acuity payments began, although some testimony appeared to indicate that the original acuity decision was made in 2010. *See* X testimony.

[13] Ex, E, pp. 22-23, J testimony; B testimony; X testimony.

[14] B testimony; J testimony; Ex. E, p. 12.

[15] Fromm Testimony; Ex. E, p. 92. While tube feeding creates a risk for aspiration, the risk is lessened with a strong cough, which Ms. K has; Ms. K has not experienced aspiration as a result of her tube feedings.

[16] Ex. E, p. 93; George testimony.

[17] This "suctioning" is not "deep suctioning" within the tube itself, but rather is "secretion management" around the trach site. Fromm testimony.

[18] Fromm testimony.

[19] Q testimony. Personnel from Ms. K's group home indicate they have sometimes provided suctioning one hundred times in a day. *See* Q testimony. Her plan of care indicates that she needs suctioning "at least every fifteen minutes," although the experience of Division witnesses who visited Ms. K suggests – as well as Ms. K's 24-hour care logs, discussed below - that she does not always require suctioning this frequently.

Ms. K sometimes has difficulty sleeping.[20] Ms. K also sometimes has "focal seizures," which go unnoticed if someone is not looking directly at her. Her seizure disorder "is managed well with medications."[21] She does not stop breathing during her seizures.[22] The protocol for her seizures is generally to reassure her, and also to tend to any physical needs that may have arisen, such as readjusting her position, suctioning secretions, or ensuring that her tracheostomy tube is in place.[23]

In addition to assisting her as described above and with activities of daily living, Ms. K's caregivers also socialize and interact with her, and take her on outings in the community.[24]

According to her Plan of Care, Ms. K's "health has been fairly stable this year."[25] In fact, Ms. K has not been hospitalized in nearly three years.[26] Ms. K's mother and caregivers believe that the extra funds provided by the acuity rate have helped her maintain optimum health and avoid hospitalization.[27]

A significant area of dispute at the hearing – and one which is ultimately determinative of this appeal – is the extent to which Ms. K needs and receives actual round-the-clock one-on-one monitoring and care. Several witnesses from Facility A testified that Ms. K's providers are with her around the clock, 24-7, providing direct care or monitoring.[28] But the documentation provided in support of the Plan of Care is not consistent with that characterization. The Plan of Care itself states that "staff check on her every 10-15 minutes throughout the night."[29] Ms. K's "24-hour care logs" contain numerous entries in which her caregivers describe having "checked and observed [Ms. K] every fifteen minutes,"[30] or *entering* Ms. K's room to check on her,[31] or

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20 This is reflected in both her plan of care and in some of the "24-hour care calendar" logs submitted to SDS. *See* Ex. E, pp. 16-17 (plan of care), pp. 50 (9-17-16 care log, 12 a.m.; 1 a.m.; 11 p.m.: "encouraged to sleep"), 51 (9/17/16 care log: 12 a.m. (same); 63 (9/23/16 care log, 11 p.m.: same); 64 (9/24/16 care log, 12:00 am. – 6 a.m.: same), 66 (9/25/16, 12:00 a.m.-6:00 a.m.: same).

21 Ex. E, p. 4.

22 A testimony.

23 A testimony. There is no evidence in the record to suggest that these needs are particularly time-consuming, arise with great frequency, or otherwise require the constant direct care for which the acuity rate is intended. No staff member testified to any specific tasks ever being required or undertaken because of Ms. K's seizures, other than documenting that a seizure had occurred. *See* Q testimony.

24 A testimony; Ex. E, pp. 7-8, 14-16.

25 Ex. E, p. 4.

26 Croxton testimony.

27 A testimony; Q testimony.

28 B testimony.

29 Ex. E, p. 17.

30 Ex. E, pp. 52 (9-19-16 log; 7:00 a.m.: "checked and observed every fifteen minutes"), p. 56 (9-20-16 log, 7:00 a.m.), p. 100 (9-4-16 log, 7:00 a.m.: "checked NK every 15 minutes"); p. 104 (9-5-16 log, 7:00 a.m.: "checked and observed NK every 15 minutes"); p. 106 (9-7-16 log, 7:00 a.m.: "Checking N every 15 minutes[;] observe breathing"); p. 110 (9-9-16 log, 7:00 a.m.: "Observed NK's breathing, check her every 15 minutes."); p. 114 (9-11-16

checking on Ms. K as the caregiver "made rounds."[32] These are all descriptions that are inconsistent with the "constant" monitoring and presence described by Facility A witnesses.

B. Division review of October 2016 proposed Plan of Care renewal

On October 4, 2016, the Division received a proposed Plan of Care renewal for Ms. K.[33] Because Ms. K receives waiver services under the IDD waiver program, her plan of care was first reviewed by IDD waiver reviewer Joanna Croxton, who then presented the Plan of Care to the Division's acuity committee for review.[34]

The acuity committee – a group comprised of different "unit managers" within the Division – met on October 21, 2016 to discuss the request for an acuity rate for Ms. K.[35] The committee included Rodney George – a retired Air Force respiratory therapist with thirteen years of direct patient care experience, and current unit manager for the Division's "CAT review" unit – and Jerold Fromm – formerly the nursing supervisor at Alaska Regional Hospital, and currently health program manager of the Division's plan of care "Review Unit."[36]

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log, 7:00 a.m.: "Checked N every 15 minutes[;] observed breathing"); p. 116 (9-12-16 log, 7:00 a.m.: "observed NK's breathing, monitored every fifteen minutes"); p. 118 (9-13-16 log, 7:00 a.m.: "checked NK every 15 minutes"); p. 120 (9-14-16 log: "observed NK and checked her every 15 minutes").

[31] Ex. E, p. 52. (9-19-16 log, 3 a.m.: "I entered NK room and checked her diaper and cleaned and changed her"), p. 94 (9-1-16 log, 1:00 a.m.: "When I entered room she was still asleep"); p. 96 (9-2-16 log, 5:00 a.m.: I entered her rom and when [illegible] the light she woke up"; 7:00 a.m.: "I went to her room and observed she was fine everything working properly."); p. 98 (9-3-16 log, 7:00 a.m.: "I went to her room and observed she was fine everything working properly."); p. 102 (9-5-16 log, 3:00 a.m. and 4:00 a.m. entries: "I entered NK's room"); p. 104 (9-6-1-16 log, 4:00 a.m.: "NK was still sleeping as I entered her room to change her diaper"); p. 106 (9-7-16 log, 2:00 a.m.: "She was sleeping I entered her room to change her diaper;" 3:00 a.m.: "she was sleeping I entered her room to check on her."); p. 108 (9-8-16 log, 5:00 a.m.: "I did room checks and she is still sleeping."); p. 110 (9-9-16 log, 1:00 a.m.: NK was asleep when I entered room to check her she is fine"); p. 112 (9-10-16 log, 12:00 a.m.: "NK was sleeping when I went in to check on her;" 2:00 a.m.: "checked on N.K. Everything is fine."; 3:00 a.m. "Checked on N.K. while she is sleeping. Everything is fine."; 7:00 a.m. "I went to her room, NK was asleep, observed her breathing normal and everything working fine"); p. 120 (9-14-16 log, 1:00 am.: "I entered her room after count and she had fallen asleep");

[32] Ex. E, p. 58 (9-21-16 log, 12:00 a.m.: "NK is asleep as I make rounds"); p. 60 (9-22-16 log, 12:00 a.m.: same); p. 70 (9-27-16, 12:00 a.m.: "NK is awake as I make rounds."); p. 94 (9-1-16 log, 12:00 a.m.: "made room checks;" 3:00 a.m. :"NK was still sleeping with no concerns as I made rounds"); p. 96 (9-2-16 log: 12:00 a.m.: "NK was asleep when I made rounds, she was resting well;" 1:00 a.m.: "NK was still asleep [when] I made rounds."); p. 102 (9-5-16 log: "I made rounds and NK was still dry and sleep all went well"); p. 104: (9-6-16 log, 12:00 a.m.-1:00 a.m. entry: "NK was awake after I made count and did rounds. I covered her with another blanket. On the next round, NK was sleep for the night."); p. 106 (9-7-16 log, 1:00 a.m.: "She was still sleeping as I made second rounds for the night."); p. 108 (9-8-16 log, 6:00 a.m.: "On the last round she was still sleeping."); p. 110 (9-9-16 log, 3:00 a.m.: "Made rounds and NK is sleeping well at this time. No suction given.")

[33] Ex. D, p. 1.

[34] Croxton testimony.

[35] Ex. E, p. 129.

[36] George testimony; Fromm testimony.

During the review process, the committee realized that Ms. K had not been observed in the group home setting while receiving the acuity rate.[37] Accordingly, Mr. George, Ms. Croxton, and Mr. Fromm arranged to visit the group home to observe Ms. K. Mr. George explained that the purpose of the visit was that the team "wanted to make sure we made the right decision."[38]

The visit lasted approximately thirty minutes, but Ms. K was only present part of that time.[39] This is because Ms. K was still completing her morning care routine when the team arrived, and was brought into the common area after her morning care routine was finished.[40] While it is unclear exactly how long the team spent with Ms. K during their visit, both health care providers on the team felt the visit was sufficient to determine that Ms. K did not currently require direct one-on-one care twenty-four hours per day.[41]

In his review of Ms. K's materials, Mr. George had had "questions about some of the things written in the Plan of Care," so wanted to observe Ms. K directly. Mr. George had been surprised by the Plan's description of suctioning at least every fifteen minutes, as he had "never had a patient that required that amount of suctioning on a continuous basis over a large number of days."[42] When he visited the home and observed Ms. K, though, she did not require the near-constant suctioning described in the Plan, and did not otherwise appear to demonstrate a level of care consistent with the acuity payment.[43]

Ms. K did not require any suctioning during the acuity team's visit.[44] Her breathing was relaxed and unlabored, and she did not cough at all while the team was there.[45] She gave the impression of being "very stable."[46] Mr. George came away from the meeting "absolutely sure"

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37 Croxton testimony.

38 George testimony.

39 George testimony; Fromm testimony.

40 Fromm testimony; George testimony; Q testimony.

41 Fromm testimony; George testimony. It is more likely than not that the team spent 15-20 minutes with Ms. K. Mr. George testified credibly that the visit lasted "roughly thirty minutes." Ms. Q testified that she arrived at "about the same time," and had to wait 5-7 minutes before Ms. K was ready. Her estimate that the team spent "maybe ten minutes" with Ms. K is more likely than not an understatement of the time of the visit, in light of the other evidence of a 30-minute visit and her estimate of only waiting "5-7 minutes" before Ms. K was ready. Mr. George also testified credibly that while waiting, he discussed Ms. K's status with Ms. Q, who described her as stable and not needing special monitoring equipment.

42 George testimony. Mr. George explained that a tracheostomy is placed specifically to manage the airway and lessen the degree of direct management needed. This testimony, and the conclusion that needs associated with a tracheostomy would not require direct one-on-one care 24 hours per day, was corroborated by Dr. Malter's testimony.

43 George testimony.

44 George testimony; Fromm testimony. Mr. George further explained that, if anything, he would have expected a higher than usual need for suctioning because Ms. K had just had her morning care routine and been moved into the common room, and secretions tend to increase after activity.

45 George testimony.

46 George testimony.

that Ms. K did not meet the level of care associated with the acuity waiver.[47] Mr. Fromm likewise did not believe that Ms. K displayed a need for constant one-on-one care.[48]

C. Denial, administrative appeal, and evidentiary hearing

On November 7, 2016, the acuity committee denied the request for an acuity rate for Ms. K. The Division formally denied the request for continued acuity payments in a November 15, 2016 letter that otherwise approved the Plan of Care.[49]

On November 18, 2016, Ms. A, Ms. K's guardian, requested a hearing to challenge the denial.[50] The hearing was initially scheduled for December 19, 2016. Due to a last-minute scheduling issue involving one of the Division's witnesses, the hearing was then postponed to January 12, 2017. On January 9, 2017, Ms. K's care coordinator submitted a letter from Ms. K's medical provider, X T, MD.

The telephonic hearing then convened on January 9, 2017. Ms. A represented Ms. K; the Division was represented by Fair Hearing Representative Victoria Cobo. Testimony was taken from Joanna Croxton, Rodney George, and Jerold Fromm (all from the Division); Ms. A; Care Coordinator L J; and T X, U T, M Q and W B (all from Facility A). Because of the late submission of Dr. T's letter, the Division requested to reconvene the hearing at a later date to take further testimony from an additional witness, Medicaid program medical director Alex Malter, M.D. The hearing reconvened on January 20, 2017, and Dr. Malter's testimony was taken. Ms. A also presented additional testimony. The parties were allowed to submit written closing arguments. The record closed on January 20, 2017.

IV. Discussion

Acuity payments are available to support a recipient receiving residential supported living or group home habilitation services only if the recipient's physical or behavioral condition is such that the recipient requires direct one-on-one care 24-hours per day to meet the recipient's need for such services. While group home staff generally provide services to multiple residents, the acuity rate's function is to continuously provide dedicated service to one resident.

The Division argues that an acuity rate is not warranted here because the needs at issue are simply needs the group home should be fulfilling anyway. Because the Division's argument appears to misapply the controlling regulation, the requirements of that regulation are first

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47 George testimony.
48 Fromm testimony.
49 Ex. D, p. 1.
50 Ex. C.

addressed. 7 AAC 130.267(a) provides that "[t]he department will approve an acuity payment for additional services for a recipient who is eligible for and receiving . . . (i) residential supported living services" or "(ii) group home habilitation services," and who is qualified under section (b). Subsection (b)(2) then defines a "qualified recipient" as one who "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."[51]

The reference to "providing services under section (a)(1)(A)" is a reference to either "(i) residential supported-living services under 7 AAC 130.255," or "(ii) group home habilitation services under 7 AAC 130.265(f)." In other words, an acuity rate is appropriate if a recipient's physical or behavioral needs are such that providing the recipient with group home habilitation services requires direct one-on-one support 24 hours per day, seven days per week, across environments. It is thus not disqualifying, as the Division seems to suggest, that the need for direct one-on-one 24-hour care is due to the extra time a recipient requires for services that are covered by group home habilitation.

In other words, the Division is incorrect when it argues that an acuity payment is inappropriate per se because the needs at issue are needs the group home is expected to manage by virtue of being a provider of group home habilitation services. To the contrary, the Department's regulations contemplate an acuity payment precisely where those very needs require "direct one-on-one support from workers whose time is dedicated solely to" providing *those services* "to that one recipient 24 hours per day, seven days per week, in all environments in which the recipient functions."[52]

In this case, however, and despite Ms. K's significant needs, the Division has met its burden of showing that an acuity rate is not warranted at this time. During the hearing, Ms. K's guardian argued that the extra funds associated with the acuity rate were necessary to enable Ms. K's group home to meet her higher needs. She argued that group home staff members are generally unskilled, must be trained to do tasks such as suctioning, have high turnover, and must meet the needs of multiple high-needs residents while also completing numerous other tasks and chores.[53] But both the acuity rate regulation and prior decisions interpreting it require more than this. A recipient must require round-the-clock services by a staff member dedicated to that

[51] 7 AAC 130.267(b) (emphasis added).
[52] 7 AAC 130.267(b).
[53] A testimony.

recipient alone; frequent observation, checking, and repositioning "do not constitute continuous attendance" and do "not satisfy the regulation's stringent requirement that [a recipient] require 'dedicated one-on-one staffing 24 hours per day.'"[54]

The Division presented credible testimony from Dr. Malter, Mr. George, and Mr. Fromm that Ms. K's tracheostomy-associated care does not require round-the-clock monitoring and supervision. More broadly, the documentary evidence (the care logs) does not support that Ms. K is receiving direct, one-on-one services 24 hours per day. To the contrary, those logs document that Ms. K receives various services over the course of the day, as is expected in the group habilitation context.[55] While Ms. K's needs are undisputedly higher than even most waiver recipients, she does not require direct one-on-one services 24 hours per day.

The letter from Ms. K's physician does not compel a different conclusion. Dr. T, who did not testify, wrote that Ms. K:

> [R]equires constant supervision to maintain her airway, manage her chronic constipation, provide food and fluids through her gastronomy tube, frequent change her position to avoid further skin damage, [and] do range of motion exercises on her contracted limbs.[56]

Undoubtedly, the letter confirms that Ms. K is a very high needs individual with multiple debilitating disabilities, and strongly supports Ms. K's receipt of waiver services. But the letter is not reasonably interpreted as requiring direct one-on-one care around the clock and in all settings. Dr. Malter testified that, as a medical professional, he understands Dr. T's letter to speak to the need for the level of supervision and support associated with the waiver program generally, rather than to suggest a need for 24-7, one-on-one care. Nor do the care logs support that Ms. K is "constantly" receiving the services described by Dr. T.

Ms. A and others have argued that the acuity rate is warranted because they fear Ms. K will experience some sort of health emergency while not in a caregiver's line of sight, and will be unable to voice her distress. As a threshold matter, this concern is simply too speculative to form a basis for an acuity payment. Further, multiple witnesses testified credibly that a pulse oximeter could be effectively used as a monitoring tool to alert Ms. K's caregivers if she were to

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[54] *See In re: S.H.*, OAH Case No. 12-0645-MDS (Commissioner of Health and Social Services, November 2012) (interpreting regulation to mean that "the staff member's duties are devoted entirely to one particular resident"); *In re: L.C.*, OAH Case No. 12-0616-MDS (Commissioner of Health and Social Services, November 2012) ("In other words, Ms. C's needs must be intensive enough that she requires one staff person, devoted to her and her alone, 24 hours per day, in order to avoid institutionalization").

[55] As noted above, testimony to the contrary was not persuasive. A fact-finder would have to discredit the 24-hour logs entirely in order to accept the testimony that Ms. K's care providers are providing direct one-on-one care 24 hours per day across all settings. The testimony did not establish a basis for doing so.

[56] T letter dated January 13, 2017.

experience any distress while not under direct supervision by a staff member. This device would sound an alarm if either her heart rate rose or her oxygen saturation level fell beyond a designated threshold level. Ms. K's care providers have not tried to monitor her vital statistics using a pulse oximeter. When Mr. George asked at the home visit about whether such measures were in place, he was told they were not needed because Ms. K was considered stable and not in need of that level of monitoring.

To the extent witnesses from Facility A argued that group home staff are not always immediately available to tend to the emergency needs of a resident – for example if both staff members were providing hands-on assistance to one of the other residents – this argument asks too much of the acuity rate. An acuity payment is not available for every recipient for whom a medical emergency might theoretically arise while the recipient's caregiver is not immediately on hand. Rather, an acuity payment is available only where a recipient actually requires directly one-on-one services 24 hours per day. While Ms. K's needs are extensive, they do not rise to this level. Both the care logs and the credible testimony of multiple witnesses support the conclusion that Ms. K does not currently qualify for the acuity rate. The Division's decision is therefore upheld.

V. Conclusion

There is no doubt that Ms. K's mother and caregivers want the very best for her. There is no doubt that Ms. K is severely disabled and has very high needs. She does not, however, require direct one-on-one care or supervision 24 hours per day. While Ms. A's desire to continue receiving a higher level of support for Ms. K is understandable, the evidence in the record does not support a finding that Ms. K satisfies the standard for an acuity rate at this time. Accordingly, the Division's denial of the acuity rate is affirmed.

DATED: January 25, 2017.

By: *Signed*
Cheryl Mandala
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 8th day of February, 2017.

By: *Signed*
Name: Cheryl Mandala
Title: Administrative Law Judge

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