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

In the Matter of:	)	
	)	
E D	)	OAH No. 12-0658-MDS
	)	Agency No.

DECISION

I. Introduction

E D has been receiving benefits under the Medicaid Home and Community- Based Waiver program for adults with physical disabilities since 2007. She was re-evaluated for eligibility in January of 2012, and the Division of Senior and Disabilities Services (division) determined she was no longer eligible for this program. Ms. D appealed that decision and requested a hearing.

A hearing was held on September 12, 2012 and October 23, 2012. A supplemental hearing was set for November 21, 2012, to hear testimony from Ms. D's treating physician as he had been unavailable on the prior hearing dates. Ms. D requested a further continuance because her physician was still unavailable. The division opposed that request, and for reasons stated on the record, the request was denied.

Both parties were represented by counsel. Both parties submitted closing briefs and replies to the opposing party's closing brief. Based on the evidence in the record, and the arguments made by counsel, the division's decision to terminate benefits is upheld.

II. Background Facts

The factual background for this case is not in dispute. Ms. D is 56 years old. She has participated in the waiver program since 2007. Ms. D has multiple diagnoses including fibromyalgia, back pain, depression, COPD, and disc degeneration.[1] In January of 2012, Ms. D was re-evaluated and found to be ineligible for the waiver program.[2]

III. Discussion

A. Medicaid Home and Community-Based Waiver Program

An adult with a physical disability is eligible to receive benefits under the Medicaid Home and Community-Based Waiver program, also called the Choice Waiver program, if he

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[1] Exhibit E, page 3; Exhibit 1 (letter from treating physician).

[2] *See* Exhibit D.

or she meets the eligibility requirements, including requiring the level of care that is normally provided in a nursing facility.[3] If eligible, the program pays for services that allow the recipient to stay in his or her home – or in an assisted living home – rather than move into a nursing facility. The level of care that is provided in a nursing facility is described by regulation. Skilled nursing facility services are defined in 7 AAC 140.515. Intermediate care facility services are defined in 7 AAC 140.510.

The division determines whether an applicant requires nursing facility level of care services by conducting an assessment.[4] For adults with disabilities, this assessment looks at the nursing level services defined in 7 AAC 140.510 and 515,[5] and incorporates the results of the Consumer Assessment Tool (CAT).[6] The CAT is an evaluation tool created by the Department of Health and Social Services, and is adopted by reference in 7 AAC 160.900(d)(6).

Once an individual has qualified to participate in the choice waiver program, certain requirements must be met before he or she can be removed from that program. Specifically, the individual must have had an annual assessment, the assessment must find that the individual has materially improved, and the assessment must have been reviewed by an independent qualified health professional.[7] For adults with disabilities, the qualified health professional must be a registered nurse licensed in Alaska qualified to assess adults with physical disabilities.[8] Material improvement for an adult with physical disabilities is defined as

> no longer has a functional limitation or cognitive impairment that would result in the need for nursing home placement, and is able to demonstrate the ability to function in a home setting without the need for waiver services.[9]

The same criteria used in making the initial determination that he or she did have a limitation or impairment in determining are used to determine whether a recipient no longer has a functional limitation or cognitive impairment.[10]

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3 7 AAC 130.205(d)(2).
4 7 AAC 130.230.
5 7 AAC 130.230(b)(2)(A).
6 7 AAC 130.230(b).
7 AS 47.07.045(b)(1) – (3).
8 AS 47.07.045(b)(2)(B).
9 AS 47.07.045(b)(3)(C).
10 7 AAC 130.230(g).

B. Opportunity to Question Reviewing Nurse

One of the preliminary questions in this case was whether Ms. D had the right to examine the independent health care professional who reviewed the division's determination pursuant to AS 47.07.045(b)(2). By regulation, Ms. D had the right to "question or refute testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses."[11] However, the reviewing nurse was not called as a witness. In fact, the name of this nurse was not even disclosed.[12]

The ability to cross-examine an adverse witness does not mean that a party has the right to insist that every division employee or agent be available as a witness at the hearing. Thus, the pertinent question is not whether Ms. D has the right to cross-examine this nurse, but whether the division is able to meet its burden of proof without calling the nurse as a witness.

As discussed above, the division must prove two broad categories of fact by a preponderance of the evidence.[13] First, it must prove material improvement. Second, it must prove that the division's determination was reviewed by a registered nurse, licensed in Alaska.[14] In this case, the division called as a witness an employee of its contractor, Qualis Health. That employee was able to review business records to determine that the review occurred, that the reviewing nurse concurred with the division's determination, and that the reviewing nurse was licensed as a registered nurse in Alaska.[15] Ms. D had a full opportunity to cross-examine this employee as to these three elements of the division's case. The division was not required to also call as a witness, or make available for questioning, the nurse who actually performed that review.

To the extent that the division might want to rely on this review to support the first category of fact – that Ms. D has materially improved – the failure to identify this witness and make him or her available for questioning would be a problem. Qualis Health's review may be relevant and admissible to prove material improvement, but the absence of the witness who

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[11] 7 AAC 49.120(5).

[12] The division's contractor, Qualis Health, asserted that disclosure of the nurse's name was prohibited by 42 C.F.R. §480.139(b)(2). Qualis Health's position is based on what may be an incorrect assumption that this federal regulation applies to the review of Choice Waiver terminations. This decision does not turn on whether the regulation does apply, and therefore no resolution of that issue is required here.

[13] The division has acknowledged in its closing briefs that it has the burden of proof.

[14] Although not specifically stated in the statute, the legislature likely intended that this review concur with the division's determination before benefits could be terminated. It makes no sense to require a review if that review could be ignored by the division.

[15] Testimony of Dion Westmoreland.

conducted the review would seriously detract from the weight given to that evidence because the reviewer's conclusions would not be explained through examination and cross-examination. In this case, the evidence from the division's contractor has been used only to support the division's claim that the required review occurred. The division has proven that it is more likely true than not true that a registered nurse licensed in Alaska reviewed the division's determination and concurred with the division.[16]

C. Material Improvement

Another preliminary issue that the parties have disputed is the extent to which the division must show a change from a prior assessment in order to prove material improvement. Ms. D has argued that the division must prove both that the most recent assessment shows she is not eligible and that this represents an improvement from her prior condition. This reads too much into the statutory requirements.

The legislature has stated that Choice Waiver benefits may only be terminated if the recipient has materially improved. The legislature has also provided a definition of material improvement. A person has materially improved if he or she

> no longer has a functional limitation or cognitive impairment that would result in the need for nursing home placement, and is able to demonstrate the ability to function in a home setting without the need for waiver services.[17]

This statute only applies to individuals who have previously qualified for the Choice Waiver program. In other words, it applies to individuals who, in the past, have had a functional limitation or cognitive impairment of sufficient severity that they needed nursing home level of care. When someone has qualified for this program in the past, and now no longer qualifies, there has been a change in circumstances and, by legislative definition, a material improvement.[18] The division can meet its burden of proof for terminating benefits by establishing through the CAT assessment that an individual no longer meets the eligibility requirements for participating in this program.[19]

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[16] In cases where there is a serious dispute as to whether the review occurred and was conducted by a registered nurse, the division might need to call the nurse as a witness to meet its burden of proof. In this case, Ms. D wished to challenged the nurse's conclusions rather than challenge the fact that the review occurred.

[17] AS 47.07.045(b)(3)(C).

[18] The only time this would not be true is when a person had been *incorrectly* found eligible for the program in the past. There is no constitutional or statutory bar to terminating benefits that should not have been granted in the first place as long as the correct procedural steps are taken before the benefits are terminated.

[19] 7 AAC 130.210(a)(1) (benefits terminated because recipient no longer eligible under 7 AAC 130.205(d)).

This does not mean that prior CAT assessments are irrelevant. Evidence that an individual has previously been eligible for the Choice Waiver program, combined with evidence that his or her physical or cognitive ability has not changed, supports a reasonable inference that he or she continues to be eligible. From this, the fact finder may conclude that the current assessment might be incorrect and that the recipient is still eligible. On the other hand, this conclusion is not required. The fact that someone has previously qualified for this program does not automatically establish that he or she will never become ineligible. Whether someone remains eligible for the Choice Waiver program must be decided on the specific facts of each case, but it is possible for the division to meet its burden of proof simply by showing that the recipient no longer qualifies as shown on the CAT assessment.

D. Review of the Division's CAT Assessment

Karen Mattson, a registered nurse, visited Ms. D at her home to conduct an assessment of her physical and cognitive abilities.[20] The scores from the CAT indicated that Ms. D did not need nursing facility level of care at the time of her assessment.[21] Ms. D disputes these scores based on her need for physical therapy and on the score listed for the bed mobility activity of daily living (ADL).

There are a variety of ways in which the CAT may show that a person is eligible for the Choice Waiver program. This can be best seen by reviewing the summary page shown in Exhibit E at page 29. Section NF 1 of this page lists five questions

> a. In Section A, Nursing Services, items 1 -8, did you code any of the responses with a 4 (i.e. services needed 7 days/wk)?
>
> b. In Section A, items 9 (Ventilator/Respirator) did you code this response with a 2, 3 or 4 (treatment needed at least 3 days/wk)?
>
> c. In Section A, item 10 (Uncontrolled seizure), did you code this response with a 1, 2, 3, or 4 (care needed at least once/wk)?
>
> d. In Section A, item 11 (Therapies), was the total number of days of therapy 5 or more days/wk?
>
> e. In section E, (Physical Functioning/Structural Problems), were 3 or more shaded ADLs coded with a 3 (extensive assistance) or 4 (dependent) in self performance?[22]

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20 Exhibit E.

21 Exhibit E, page 29.

22 Exhibit E, page 29. The "shaded ADLs" are bed mobility, transfers, locomotion, eating, and toilet use.

A person who receives a "yes" answer to any one of these questions is presumed to be eligible for nursing facility level of care, and thus qualifies for the Choice Waiver program.

If a person does not qualify under section NF 1, scores are established in sections NF 2 (nursing services and therapies), NF 3 (cognitive ability), and NF 4 (inappropriate behavior). Section NF 5 states that if the total score for sections 2, 3, and 4 is zero, the individual does not qualify for nursing facility care. If the score is greater than zero, Section NF 6 is considered. Section NF 6 asks how many of the shaded ADLs were scored with a 2 or higher in self-performance and a support score of 2 or 3. In other words, how many of these ADLs received a score of 2/2 or higher.

Under Section NF 7, the score in section NF 5 is added to the score in section NF 6. An individual with a score of 3 or higher is eligible for the Choice Waiver program.

The division's assessment of Ms. D did not have any yes answers in section NF 1, and did not show a score of one or more in sections NF2 through NF 4. Accordingly, she was determined to be no longer eligible for the Choice Waiver program. However, if Ms. D required physical therapy at least three days a week, she would have received a score of 1 in section NF 2(b). With this score, it would be necessary to then look at her shaded ADLs in section NF 6.

On July 23, 2012, Ms. D's physician prescribed physical therapy three times per week.[23] The division argues that this prescription should be ignored because there is no evidence that Ms. D is or was actually receiving physical therapy. The CAT is an assessment of an individual's needs. It measures whether someone needs nursing facility care, not just whether that person is already receiving nursing care. A person may be eligible for the Choice Waiver program even if he or she is not currently receiving the services that would establish eligibility. This can best be seen by looking at this issue from the view point of initial eligibility. A person who needs daily injections or daily treatment for a decubitus ulcer (bed sore) would receive a score of 4 in Section A, Question 2 or 4.[24] This score would be given even if the person did not have someone available to provide that service. In fact, the reason for applying for the Choice Waiver program might be to obtain financial assistance because the individual would not otherwise be able to

[23] Exhibit 2, page 5.
[24] Exhibit E, page 13.

afford this service. Receiving a score of 4 on either of these questions would qualify the applicant for services in section NF 1.[25]

The prescription for physical therapy is relevant evidence of Ms. D's need for that therapy. Since it comes from her personal treating physician, it is particularly persuasive evidence of that need.[26] However, the prescription was not written until over six months after the division's assessment.

A person's needs for assistance or therapy after the date of the assessment can be used to show that the same assistance or therapy was needed at an earlier date. This is especially true when combined with other evidence about the stability of the person's condition. But, all other things being equal, this evidence becomes less persuasive as time period between the assessment and the additional evidence becomes longer.

In this case, there was no information provided to Ms. Mattson in January of 2012 that Ms. D needed physical therapy. While the division's assessor should attempt to look for other needs beyond the answers provided by the recipient, the assessor is dependent on the information provided by others during that assessment. Ms. D's care coordinator was present during the assessment.[27] There is no evidence that either Ms. D or her care coordinator indicated a need for physical therapy at that time. Prior assessments did not indicate a need for physical therapy.[28] The prescription six months after the assessment does not outweigh the evidence gathered during the assessment and, it is more likely true than not true that Ms. D did not need physical therapy as of the date of her January 2012 assessment.

Without the need for physical therapy or any of the other needs identified in NF 2 – NF 4, Ms. D would only be eligible for the Choice Waiver program if three or more of the shaded ADLs were scored with a three or higher for self performance (section NF 1 e). The division's assessment gave Ms. D a score of 3 for the ADL of transfers.[29] Ms. D argues that she should receive a high score in bed mobility.[30] She did provide evidence on this point, but even if this ADL was scored with a 3 or higher, she would only have a score of 3 or higher in two of the

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25 Exhibit E, page 29.

26 *See Hiler v. Astrue*, 687 F.3d 1208, 1212 (9th Cir. 2012) (In Social Security disability appeal, treating physician's opinion generally carries more weight than other physician testimony.)

27 Exhibit E, page 2.

28 Exhibit 3,page 2 and 6 (2008 CAT); Exhibit 4, page 2 and 6 (2009 CAT); Exhibit 5, page 5 (2010 CAT); Exhibit 6, page 6 (2011 CAT).

29 Exhibit E, page 18.

30 Claimant's Closing Brief at 7.

shaded ADLs. Ms. D did not argue for, and the evidence would not support, a score of 3 or higher in locomotion, eating, or toilet use. Because she, at the most, would have scores of 3 on only two shaded ADLs, she would not have been eligible for the Choice Waiver program as of the date of the assessment.[31]

IV. Conclusion

The evidence presented at the hearing shows that Ms. D is in need of assistance with Activities of Daily Living, but that she does not meet all of the eligibility requirements for the Choice Waiver program. Accordingly, the division properly determined that her participation in that program should be terminated.

DATED this 7th day of January, 2013.

Signed
Jeffrey A. Friedman
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 23rd day of January, 2013.

By: *Signed*
Name: Jeffrey A. Friedman
Title: Administrative Law Judge

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

[31] Based on the need for physical therapy in July, and the evidence regarding her need for assistance with bed mobility, she may be eligible now, and may wish to reapply for this program.