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

In the Matter of	)	
	)	
T C	)	OAH No. 13-0204-MDS
	)	Agency No.

FINAL DECISION

I. Introduction

T C has been receiving services under the Older Alaskan or Adult with a Physical Disability Waiver program, also known as the Choice Waiver program. The Division of Senior and Disabilities Services (Division) re-assessed her functional abilities, and concluded that Ms. C was no longer eligible to participate in the Choice Waiver program. The assessment visit on which this termination was based was conducted by Nurse Moli Atanoa on August 30, 2012. The Division issued a letter to Ms. C, entitled "Denial of Alaska Waiver Payment for Waiver Services," on February 5, 2013.[1]

Ms. C, who is represented by counsel, requested a hearing to contest that determination. Because the Division proposed terminating benefits previously granted, it had the burden of proving at the hearing that Ms. C was no longer eligible.[2]

II. Procedural History

After an initial continuance at the request of the Division, the evidentiary hearing in this case was held in four sessions between April 10 and May 9, 2013. The administrative law judge (ALJ) issued a proposed decision on June 24, 2013. The proposed decision found that the Division had not proved Ms. C to be ineligible for Waiver services.

By delegation from the Commissioner of Health and Social Services, the designated final decisionmaker in this case is Jared Kosin, Executive Director of the Office of Rate Review. As permitted by Alaska Statute 44.64.060, the Division filed a Proposal for Action urging Mr. Kosin to modify the ALJ's proposed decision.

The Division's Proposal raised four independent criticisms of the proposed decision. One of those criticisms was an argument growing out of the view that the August 2012

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1 Ex. D.

2 7 AAC 49.135.

assessment by Nurse Atanoa was, in fact, the "final decision" of the agency, and that the denial letter written half a year later was simply a notice of that decision. Mr. Kosin, acting under authority of AS 44.64.060(e)(2), returned the case to the administrative law judge to conduct additional proceedings to evaluate that contention alone, framing the question as follows:

> Whether the applicable statutes and regulations support the conclusion that the date of the final decision that a recipient of Waiver services is no longer eligible to participate in the Waiver program is the date of the CAT assessment or whether the applicable statutes and regulations support the conclusion that it is the date of the denial letter that is sent to the recipient.

The question returned to the ALJ was purely one of law and policy. With the concurrence of the parties, a special procedure was adopted whereby the ALJ and Mr. Kosin would jointly hear oral argument from the parties on this single question. They would also deliberate jointly during preparation of a revised decision.[3]

In the decision below, all findings of fact from the original proposed decision have been left undisturbed except for minor clarifications. Application of law and policy to those facts has been revised, where appropriate, to reflect the new arguments of the parties.

III. Background Facts

Ms. C was admitted to the Choice Waiver program in 2007 at the age of 40. Her admission followed a 2006 automobile accident in which she received a traumatic brain injury; in addition, she had suffered a MRSA infection to an injured knee and was, at the time of her 2007 assessment, receiving daily professional nursing care for a wound on the knee.[4] The professional nursing care she was still receiving for the knee wound was sufficient, in itself, to qualify her automatically for Waiver services.[5]

The Division visited and reassessed Ms. C on August 30, 2012. Based largely on a Consumer Assessment Tool (CAT) compiled from that hour-long visit by Moli Atanoa, R.N., the

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[3] *See* Procedural Order for Remand (July 11, 2013). This procedure, while unusual at first glance, is consistent with the underlying nature of the proceedings at this level. Mr. Kosin's role in this case is that of chief executive branch decisionmaker. He is not conducting an appellate review. He had before him a proposed decision, essentially a draft of the final decision he would enter. He determined, based on briefing from the Division, that the proposed decision needed more work in a specific area. He exercised a statutory option to "return" the matter to the administrative law judge for "specific proceedings." Here, with concurrence of the parties, those proceedings included allowing him to hear the parties' legal arguments firsthand.

[4] Ex. F.

[5] *Id.* at 1, 13. Contrary to the Division's assertion at hearing, she no longer had a PICC line at the time of her 2007 assessment, but she was still receiving skilled care.

Division concluded that Ms. C was no longer eligible for this program.[6] This conclusion grew out of findings that Ms. C no longer needed professional nursing services, and was not wholly dependent nor in need of extensive assistance with at least three activities of daily living.[7] The Division made its decision in early February of 2013, about five and a half months after the assessment.

T C has a number of serious medical challenges, most stemming directly or indirectly from her accident. Her current conditions include traumatic brain injury, thoracic outlet syndrome (a type of nerve impingement), foot drop due to a severed nerve in her back, migraines, peptic ulcers, obesity, incontinence, irritable bowel, chronic pain, bipolar disorder, depression, anxiety, panic attacks, and post-traumatic stress disorder.[8] Ms. C has had three falls in the seven months between October 2012 and May 2013: once trying to do a transfer from her bed by herself, once in the shower, and once while in regular locomotion in the hallway.[9] As of February 2013, she had 22 pharmaceutical prescriptions.[10]

This case turns primarily on the accuracy of Ms. Atanoa's CAT assessment as a measurement of Ms. C's care needs half a year later, at the time of the decision. While other professionals reviewed the C termination on behalf of the Division, they did not independently assess Ms. C, relying upon (and repeating almost verbatim) the observations recorded in the CAT.

IV. Discussion

A. Home and Community-Based Waiver Program

An adult with a physical disability is eligible to receive benefits under the Choice Waiver program if he or she requires the level of care that is normally provided in a nursing facility.[11] The program pays for services that allow an eligible person to stay in his or her home (which may be 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.

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6 Ex. D.
7 Ex. E at 30.
8 Ex. H at 0188; cross-exam of Moli Atanoa.
9 Direct exam of K N; *see also* Ex. 3, 4.
10 Ex. 5.
11 7 AAC 130.205(d)(2).

The Division determines whether an applicant requires nursing facility level of care services by conducting an assessment.[12] For adults with disabilities, this assessment looks at the nursing level services defined in 7 AAC 140.510 and 515,[13] and incorporates the results of the CAT.[14] The CAT is an evaluation tool in the nature of a questionnaire and scoring mechanism. Because it is adopted by reference in 7 AAC 160.900(d)(6),[15] it is itself a regulation.

Once an individual has qualified to participate in the Choice Waiver program, there are additional protections before he or she can be removed from that program. Specifically, the individual must have had an annual assessment, the assessment must have been reviewed by an independent qualified health professional, and the assessment must find that the individual has materially improved.[16] For adults with disabilities, the qualified health professional must be a registered nurse licensed in Alaska and qualified to assess adults with physical disabilities.[17] 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.[18]

The criteria used in determining whether a recipient no longer has a functional limitation or cognitive impairment are the criteria listed for making an initial determination of limitation or impairment.[19]

In the present case, Ms. C's condition has certainly improved in some respects; most notably, she no longer requires daily skilled nursing care for a MRSA infection and knee wound. However, to meet the above threshold for removal from the program, she must have improved to a degree that she no longer requires and qualifies for Waiver services. For practical purposes, therefore, the essential question in this case is whether the Division has demonstrated that Ms. C no longer qualifies for the program.

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12 7 AAC 130.230.
13 7 AAC 130.230(b)(2)(A).
14 7 AAC 130.230(b).
15 Adopting January 29, 2009 version of the CAT.
16 AS 47.07.045(b)(1) – (3).
17 AS 47.07.045(b)(2)(B).
18 AS 47.07.045(b)(3)(C).
19 7 AAC 130.230(g).

B. Parameters for Review of the Division's Evaluation of Eligibility

The Division has raised two closely related arguments regarding the nature and scope of the review the Commissioner (or his designee) is permitted to conduct in the Fair Hearing process. First, the Division takes the position that the staff "decision" the Commissioner must review occurred on August 30, 2012, when Nurse Atanoa visited Ms. C and made her observations. Relatedly, the Division argues that the medical condition relevant to all proceedings in the Fair Hearing process is Ms. C's condition on August 30, 2012, with subsequent developments irrelevant and out of bounds for consideration.

As explained below, the Division's first position grew out of a misreading of the statute. Nurse Atanoa was not a decisionmaker, and neither she nor the Division made a decision on August 30, 2012. The Division's second position is a litigation position that may be inconsistent with the way the Division itself actually has been interpreting the law it administers. In any event, to adopt the new restriction on evidence that the Division's counsel has proposed would be legally impossible in the present case, and could be problematic from a policy standpoint if adopted for future cases.

1. Decision Under Review

In its briefing and oral argument challenging the initial proposed decision at this level, the Division presented a model of decisionmaking within the Department of Health and Social Services akin to the levels of appeal in a multi-tiered court system. For Waiver termination decisions like this one, the Division posited the following sequence:

> 1. A nurse visits the Waiver recipient and conducts an assessment. The nurse *decides*, on behalf of the Division, if the recipient is eligible. Of critical importance to the Division's model, the Division says that "the decision occurs at the assessment."[20]
>
> 2. An "independent qualified health care professional" reviews the "decision" under AS 47.07.045(b)(2), either affirming or reversing that decision.[21]
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> 3. If the independent reviewer affirms the original decision, the decision may be further appealed by the recipient to the hearing authority under 7 AAC 49, who may likewise affirm or reverse the original decision.

[20] Division's Proposal for Action at 5.

[21] In addition to this outside review, it is also the Division's practice to do an internal review by a second Division nurse (*see, e.g.*, Ex. D at 1), but this internal review is not mandated by law and was not part of the sequence of "decisions" in the Division's legal model.

It is important to note that a recipient receives no formal notice at step 1. A letter to the recipient is issued after step 2. In this case, the letter was issued in February 2013, more than five months after the August 2012 assessment visit; it was titled a "Denial of Alaska Waiver Payment for Waiver Services" and said that "[i]f you disagree with this decision, you may request a fair hearing."[22] The Division characterizes this letter as merely a notice of a decision made months previously at step 1.

The Division believes its concept of the process is plainly and unequivocally mandated by statute. The Division's model was crystallized in the following colloquy at oral argument:

> Mr. Kosin: What is the point of the independent review? Because how can a decision—how can the agency conclude on the date of the assessment that their decision is made and still require an independent review? I don't see how those concepts come together.
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> Ms. Allen: Well, the statute is very clear that the independent review is of the agency's decision.
>
> Mr. Kosin: Okay.
>
> Ms. Allen: So it *has* to be a decision, first, for it to be reviewed.[23]

A close examination of the statute shows that the Division's model is built on a mistaken premise. The statute the Division is referring to, AS 47.07.045, reads in relevant part as follows:

> (b) Before the department may terminate payment for [Waiver] services . . . ,
>
> (1) the recipient must have had an annual assessment to determine whether the recipient continues to meet the standards [for the Waiver program];
>
> (2) the annual assessment must have been reviewed by an independent qualified health care professional under contract with the department; for purposes of this paragraph, "independent qualified health care professional" means,
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> (A) for a waiver based on mental retardation or developmental disability . . . [inapplicable];
>
> (B) for other allowable waivers, a registered nurse licensed under AS 08.68 who is qualified to assess children with complex medical conditions, older Alaskans, and adults with physical disabilities for medical assistance waivers; and

[22] Ex. D.

[23] Recording at minutes 34-35.

> (3) the annual assessment must find that the recipient's condition has materially improved since the previous assessment; for purposes of this paragraph, "materially improved" means that a recipient who has previously qualified for a waiver for
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> . . .
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> (C) an older Alaskan or adult with a physical disability, 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.

As can be seen, the Division's recollection of what language the statute contains is mistaken. The statute does not mention a "decision" at all. Instead, it sets up three prerequisites "before the department may terminate" Waiver services. Plainly, the department cannot lawfully decide to terminate Waiver services until these prerequisites have been met. There must first be an assessment, the assessment must go through independent review, and then the assessment, as reviewed, must find that the individual is no longer qualified.

In the present case, these three prerequisites were not met until January 28, 2013. One week afterward, the Division issued a six-page document titled "Denial." This document, signed by the unit manager for level of care determinations, has every appearance of being the Division's decision. One might quibble over whether the document itself is the decision or is simply a notice of a decision made internally a few hours or days previously, but for practical purposes the February 5 letter is the decision under review in the Fair Hearing process. The August assessment, which was just one of three prerequisites required for a decision to terminate, is not the decision under review.

2. Medical Condition Relevant to Termination of Benefits

As will be discussed in Sections IV-C-1 and IV-C-3-a below, an important question when applying the CAT scoring mechanism is whether, and how frequently, a patient is receiving therapy. The evidence in this case will show that—more likely than not—the answer to that question differs depending whether the question is asked as of August 2012 or as of February 2013. The Division contends that evidence about the patient's status in February 2013 is irrelevant to the task before the hearing authority and must not be considered.

As a legal matter, there is a short and completely dispositive reason that, in this case at least, the later evidence must be considered. In this case, the Division's February 5, 2013 letter gave Ms. C notice of her Fair Hearing rights. In explaining these rights, the letter told Ms. C: "You may supplement your application with additional information to support your position that you meet level of care for the waiver program at anytime through the fair hearing process."[24] The notice did not invite the recipient to submit information showing that she "met" level of care at some specified point in the past; instead, it invited information as to whether she "meet[s]" level of care, in the present tense. In response to this notice, Ms. C promptly submitted a document addressing her current therapy needs and usage.[25] Having invited this kind of showing from Ms. C, the Division may not now prevail on an argument that it was the wrong kind of showing for her to make.[26]

More broadly, the Division's contention in this litigation—that the evaluation of a patient's continuing eligibility is unbreakably tethered to the exact date the assessment nurse makes her annual visit—does not seem to be consistent with the way the Division itself administers this program for other recipients. According to some Division personnel, during the interval between the assessment visit and the completion of the independent third-party review—and even afterward—the Division invites and considers new information indicating that the patient's condition has further evolved since the date of the visit and now meets level of care. Reportedly, when persuasive information of this kind is received, supervisors in the Division "change the assessment" and the Division does not terminate the patient from the Waiver program.[27] This practice may well reflect considered policy choices and legal judgments to the effect that individuals should not be terminated from the Waiver program unless they are, at the time of termination, ineligible for that program.

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[24] Ex. D at 6.

[25] There is a separate issue in this case as to whether the document was factually persuasive. That question is addressed in footnote 29. The question here is whether the subject addressed by the document is legally relevant.

[26] *See, e.g., Hidden Heights Assisted Living, Inc. v. State, Dep't of Health and Soc. Serv.*, 222 P.3d 258, 265, 270 & n.56 (Alaska 2009) (department must give a member of the public the kind of hearing it promised to give); *Carousel Studio v. Unemployment Ins. Appeal Bd.*, 1990 WL 91108, *1 (Del. Super. 1990) ("administrative hearings like judicial proceedings are governed by the fundamental requirements of fairness which are the essence of due process, including fair notice of the scope of the proceedings and adherence of the agency to the stated scope of those proceedings").

[27] Testimony to this effect, which has been received in multiple cases, was discussed during the oral argument held August 21.

In this case, in contrast, a Division attorney has advocated that the hearing authority should disregard changes in the patient's condition and uphold terminations if termination *would* have been appropriate *if* the agency had acted promptly after the assessment visit. This is argued even though the agency decision has lagged the assessment visit by many months. To accept this view would risk undermining existing agency policy. Even if the hearing notice were not dispositive in this case, the hearing authority would hesitate to impose such a change absent a much stronger showing that it is a wise and legally sound approach.

Accordingly, in applying the CAT methodology below, this final decision will not disregard evidence of developments in the patient's condition and care needs that came about during the long interval between the assessment visit and the Division's decision to terminate.[28] In other words, it is not Ms. Atanoa's assessment visit that will be deemed to be on appeal, but rather the Division's decision. An assessment visit showing lack of eligibility is a necessary condition for disenrollment, but it is not a sufficient condition: the recipient must actually *be* ineligible to be disenrolled. Ideally, the decision should be close in time to the assessment so that the assessed facts coincide with those at the time of decision, but in the present case there was a substantial delay.

C. The CAT

1. Scoring the CAT Assessment

There are two routes by 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 30.

Section NF 1 of this page lists five questions:

> a. In Section A, items 1-8 (Nursing Services) 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)?

[28] This accords with broader mainstream views of the manner in which the Fair Hearing process is supposed to function. *See*, e.*g.*, *In re V.D.M.*, OAH No. 12-0612-MDE (Comm'r of Health & Soc. Serv. 2012), at 2; *Parker v. New Hampshire Dep't of Health and Human Serv.*, 969 A.2d 322, 329-30 (N.H. 2009) ("The issue . . . was . . . whether the *circumstances*, not the evidence, existing as of November 7, 2006, when the Area Agency made its decision, demonstrated [that Medicaid funding for her care should be terminated]."); *Carter v. New Mexico Human Serv. Dep't*, 211 P.3d 219, 222-23 (N.M. App. 2009).

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?[29]

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

The second route for qualification is through a combination of scores given under sections NF 2 (nursing services and therapies), NF 3 (cognitive ability), and NF 4 (inappropriate behavior), and NF 6—with the last only being examined if a score of at least one was found somewhere in NF 2-4. Section NF 6 returns to the key ADLs, asking how many of them were scored with a two or higher (limited assistance) in self-performance and given a support score of two or three. In other words, it asks how many of these ADLs received a score of 2/2 or higher in the body of the assessment. The number of such raw scores becomes the single numerical score in NF 6. Under Section NF 7, the total score in sections NF 2-4 and 6 are added. An individual with a grand total of three or higher is eligible for the Choice Waiver program.

2. NF 1 Qualification in this Case

Ms. C qualified automatically under NF 1-a in 2007 due to the skilled nursing care for her wound and infection, but that care is no longer required. Presently, she does not receive skilled nursing services (NF 1-a), does not need a ventilator/respirator (NF 1-b), does not have uncontrolled seizures (NF 1-c), and the therapy she receives is less frequent than the five days per week required to qualify under NF 1-d.[30] As to NF 1-e, whereby a person can qualify based on a need for extensive assistance or total dependence in three or more key activities of daily living (ADLs), the evidence in this case supports that level of need with respect to none of the "shaded" or key ADLs, and no argument has been pressed that she can qualify under this provision. ADLs will be addressed in detail in connection with the scoring analysis for the second route to qualification.

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[29] Ex. E at 30. The "shaded ADLs" are bed mobility, transfers, locomotion, eating, and toilet use.

[30] Her physician wrote a letter attesting that she needed and received physical therapy three times per week. The only other therapy the record indicates she needs or receives is a monthly session with a psychiatrist. Cross-exam of L H. The psychiatrist sessions do not appear to be a type of therapy given a score in the CAT, and in any event the frequency is only about 0.25 days per week.

3. NF 7 Qualification in this Case

a. NF 2

Section NF 2 relates to nursing services and therapies. Ms. Atanoa gave Ms. C a total score of zero for this section, because she was unaware of any such services or therapies. Indeed, at the time Ms. Atanoa performed her assessment, it is probable (though not certain) that Ms. C was not receiving this kind of care.[31]

As discussed in Part IV-B above, however, the precise question at this stage is not what the facts were at the time of the assessment visit. As of the month the termination decision was made—half a year after the assessment—Ms. C required and was receiving physical therapy with a licensed therapist three times per week.[32] Accordingly, the correct CAT score for NF 2 *applicable to this final decision* will be a score reflecting physical therapy three times per week. Under NF 2-b, this changes the score from zero to one. None of the other zero scores in subcomponents of NF 2 are disputed. The single change in NF 2-b alters the total score in NF 2 from zero to one.

b. NF 3

Section NF 3 of the CAT processes the patient's cognitive status. It presents four questions, and the answer to all four must be "yes" for a single point to be awarded in NF 3. One of the four questions, NF 3-b, relates to whether, over the last week, the person has been able to recall season, location of room, names/faces, and where he or she is; the patient must fail in at least one of these areas to be able to receive a point.[33] Ms. Atanoa assessed these firsthand, with the care coordinator in the room and able to add any relevant information.[34] Ms. C appeared to be doing fine with all four recall categories. None of the witnesses at the hearing called into question this aspect of Ms. Atanoa's assessment as it relates to Ms. C's condition at the time of

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[31] Direct exam of Atanoa (she asked Ms. C if she was attending therapy and was told no; care coordinator did not disagree). It is not possible to be certain about this because full medical records were not gathered.

[32] Ex. 1 (letter from treating physician). This letter is much closer in time to the decision than Ms. Atanoa's assessment, and it more likely than not reflects the physical therapy required at the time of the decision.

The Division was aware of this letter during the months leading up to the hearing and did not gather or offer any evidence to call it into question. As to the simple factual issue of the amount of therapy being received when the letter was written, the letter is unrebutted.

So that the record will be clear, it will be noted here that the same letter offered certain medical and legal *opinions*. The administrative law judge and the final decisionmaker have not relied on those opinions in any way in reaching the present decision.

[33] Ex. E at 16, 30.

[34] The care coordinator had checked with the care providers to learn of any concerns. Direct exam of H.

the termination decision. On the basis of NF 3-b alone, therefore, it is clear that the score of zero in the NF 3 category is appropriate.

c. NF 4

Section NF 4 relates to behavioral problems requiring professional nursing assessment, observation, and management.[35] There appears to be no dispute that Ms. C does not have these behavioral problems and that a zero score is appropriate.

d. Proceeding to NF 6

When Ms. Atanoa did her assessment in the summer of 2012, she justifiably concluded that Ms. C had no score in any of categories NF 2 through 4, and therefore—following the CAT directions—she proceeded no further.[36] Because the "one" score explained above for NF 2 means that Ms. C in fact merited a score of one rather than zero from the combination of NF 2 through 4 by the time of the decision under review, it is necessary to proceed to NF 6 at this time. NF 6 relates to the patient's need for assistance with certain "shaded," or key, activities of daily living.

Proceeding to NF 6 certainly brings Ms. C close to qualification. Ms. C only needs a total score of three to be eligible for Choice Waiver services. She gets one point from NF 2 and, as will be seen, the Division concedes that if one goes to NF 6, she gets one *more* point (for toileting assistance) in the ADL category. Accordingly, any additional point from one of the other four key ADL categories results in a qualifying score.

e. NF 6

Section NF 6 asks how many of the five "shaded" ADLs receive codes of 2/2 or higher. One point toward the final qualification is awarded for each such ADL.

The parties agree that one of the key ADLs, toileting, merits a code of 2/2 or higher, because Ms. C requires considerable assistance in this area.[37] One point must be awarded for that item.

A second shaded ADL is eating. To receive a support score of two in this area, Ms. C would have to need a person to physically assist her with eating. There is no dispute in this case that she feeds herself.[38] She receives no points for this item.

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35 Ex. E at 17, 30.
36 Ex. E at 30.
37 *See* Ex. E at 18.

A third shaded ADL is bed mobility. All evidence in this case indicates that Ms. C moves around in her bed without assistance,[39] resulting in no points for this item.

A fourth shaded ADL is transfers—moving from one surface to another, such as from chair to bed. This is a critical area, because Ms. C had been assessed by the Division itself as recently as 2011—four years after her admission to the program—as meriting a code of 2/2 in this area, indicating she needed limited physical assistance from one person for this activity.[40] If that score were maintained in the latest assessment, she would receive another point in NF 6 on top of the toileting point already established.

Ms. Atanoa lowered the code for transfers to 0/0, corresponding to no help or oversight/no physical help from staff or setup.[41] Ms. Atanoa's explanation for this change at the hearing was cursory, indicating, in response to a leading question from the Division's counsel, only that she observed Ms. C "get up and sit down, move from the chair."[42] Ms. Atanoa said Ms. C was "totally independent" with transfers.[43] At the same time, she testified that Ms. C "cannot" stand up on her own.[44] She did not indicate that she did any investigation other than watching Ms. C get up and sit down. In other words, she seems to have relied on a single moment in time even though the CAT requires coding for any assistance needed over a seven-day period.

In the face of contrary evidence, this contradictory and conclusory judgment, based on a single observation, is not a sufficient showing for the Division (which has the burden of proof in this matter) to establish so fundamental a component in the assessment. And there is contrary evidence. First, K N, who is one of Ms. C's caregivers, testified credibly and in considerable detail to the effect that Ms. C must be assisted by one person in two kinds of transfers: getting up from her bed and in transferring from a chair to her walker. Ms. Atanoa did not observe either of these activities, and the caregiver's testimony regarding this need is essentially

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38 Ex. E at 18; Direct Exam of N (ALH administrator: Ms. C cuts and eats own food). The care coordinator thought that the ALH cuts up Ms. C's food, but that impression, if correct, would correlate to a "setup only" code of 1 and would still lead to an ultimate NF 6-e score of zero.

39 Direct exam of Atanoa.

40 Ex. E at 12. Ms. Atanoa testified that "previous score" was from a 2011 assessment, not from the 2007 assessment that gained Ms. C entry into the program.

41 Ex. E-18.

42 Direct exam of Atanoa.

43 Cross exam of Atanoa at 1:50:20.

44 *Id.* at 2:08:15. She may have been referring only to a need to have something to grab onto, but even this would be difficult to square with a 0/0 code, since it would presumably entail setup help.

uncontradicted.[45] Moreover, the very fact that the Division had coded this item at 2/2 just one year previously is an indication that transfers was an area that deserved a close examination, which Ms. Atanoa does not seem to have appreciated. The 2/2 score from the previous year's assessment also shows that difficulty with transfers is not something that has developed only recently, after the February decision under review. The transfer issues were probably present in February.

Both as of the hearing date and as of February 2013, it is more likely than not that Ms. C needed as least limited physical assistance with transfers from at least one person at least three times during a seven-day period.[46] This equates to a code of 2/2 and the award of one additional point toward the NF 6 total.

The fifth shaded ADL is locomotion, moving between locations on the same floor. Regarding this ADL, the evidence the Division offered was also quite limited, but the showing was a little more complete than for transfers. Ms. Atanoa seems to have observed Ms. C to walk unassisted with a walker and to have been told by Ms. C that she can do that.[47] The Division offered no evidence of how extensively Ms. Atanoa explored whether Ms. C may have needed assistance with locomotion on occasions over the previous seven days, but Ms. C's care coordinator does confirm that Ms. C does quite well on smooth floors.[48] On Ms. C's behalf, evidence was presented that her current home supervises her locomotion at all times now with a security belt, due to her lack of balance, foot drop, and recent history of falls (the falls seem to have occurred after Ms. Atanoa's assessment took place).[49] But it is not clear whether the instability and the close assistance are something that had fully developed by February, the time of the decision under review.[50] The care plan the Division and Ms. C's care coordinator agreed to in late fall indicates that indoor locomotion was independent at that time.[51] All in all, this is an area that neither side explored in as much detail as one might desire, but it is slightly more likely than not that Ms. C was doing locomotion independently or almost independently in

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45 Ms. C's plan of care, last signed off on by the Division and by Ms. C's care coordinator in the late fall of 2012 (that is, after Ms. Atanoa's assessment but prior to the Division's termination decision), indicates that Ms. C needed transfer assistance 10 times per week with the two kinds of transfers Ms. N referred to. Ex. H at 0191.

46 I find that the need occurred at least daily, since Ms. C would have to get out of bed daily.

47 Ex. E at 7; direct exam of Atanoa at 53:00.

48 Direct exam of H.

49 Direct exam of N.

50 Ex. 3 and 4 show that one of the falls was on January 17. The timing of the other two falls is unclear.

51 Ex. H at 0191.

February, yielding an appropriate CAT code on this activity of 0/0 or 1/0 and no additional points toward NF 6.

f. Total Score

At NF 7, the points from NF 2, 3, 4, and 7 are totaled. Three or more points is a qualifying score. The correct CAT score in this case, as of February 2013 and thereafter, is one point from NF 2 and two points from NF 6. The total at NF 7 is three.

C. Factors Beyond the CAT

The CAT has been incorporated into the Department's regulations, and as the Department interprets those regulations, a qualifying CAT score creates at least a presumption that the recipient is eligible for Choice Waiver services.[52] It may be that in exceptional cases there are factors outside the CAT that might override a qualifying CAT score, but none have been suggested in this case.

Because Ms. C had a qualifying CAT score as of the time of the decision under review and thereafter, the decision must be changed. It is unnecessary to address the other grounds Ms. C has advanced for changing the decision.

V. Conclusion

Ms. C was qualified for the Choice Waiver program on the date the Division made its decision to terminate her from the program. The decision to terminate her is reversed. The date on which Ms. C shall be deemed to have met level of care is the close of evidence in this proceeding, May 9, 2013.

Recommended by:

Date: September 17, 2013

Signed
Christopher Kennedy
Administrative Law Judge

Adopted by:

Date: October 2, 2013

Signed
Jared C. Kosin
Executive Director, Office of Rate Review
(By delegation of Commissioner Streur)

[52] *See In re O.P.*, OAH No. 13-0054-MDS (Comm'r of Health & Soc. Serv., adopted Feb. 20, 2013), at 8 (http://aws.state.ak.us/officeofadminhearings/Documents/MDS/MDS130054.pdf).

Appeal Rights

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska Rule of Appellate Procedure 602(a)(2) within 30 days after the date of this decision.

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