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

In the Matter of	)	
	)	
H H	)	OAH No. 13-0678-MDS
	)	Division No.

DECISION

I. Introduction

H H receives Medicaid Home and Community-Based Waiver program ("Waiver") services. The Division of Senior and Disabilities Services (Division) notified Mr. H that he was no longer eligible for Waiver services, and that they would be discontinued.[1] Mr. H requested a hearing.[2]

Mr. H' hearing was held on July 1, 2013. Mr. H was represented by Tom Fernette from the Office of Public Advocacy. B P testified on his behalf.

Assistant Attorney General Kimberly Allen represented the Division. Sam Cornell, RN, and Jan Bragwell, RN, testified on the Division's behalf.

Mr. H' condition has materially improved since he was initially approved for Waiver services and as a result, the Division's decision terminating his Waiver services is AFFIRMED.

II. Facts

The following facts were established by a preponderance of the evidence.

Mr. H is 60 years old and resides in an assisted living home (ALH). He has multiple medical conditions. He was found eligible for Waiver services in 2009, based upon his need for assistance with medications, an impaired cognition score of 15, a difficulty behavior score of 15, and his need for limited one person assistance with locomotion and toilet use.[3] His diagnoses, at the time, were anoxic brain damage, chronic respiratory failure, malnutrition, schizophrenia, coronary artery disease, type 2 diabetes, and peptic ulcer.[4]

Mr. H was reassessed on December 26, 2012 by Sam Cornell, a registered nurse employed by the Division, to determine whether he continued to be eligible for Waiver services. Mr.

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1 Ex. D.
2 Ex. C.
3 Ex. F, pp. 4, 6 – 8, 15.
4 Ex. F, p. 26.

Cornell documented the assessment on the Consumer Assessment Tool (CAT). The assessment found the following:

- Mr. H did not require physical assistance with bed mobility, transfers, locomotion, and eating.[5]
- Mr. H required limited one person physical assistance with toileting.[6]
- Mr. H did not require professional nursing services, therapy from a qualified therapist, specialized treatment, or therapies.[7]
- Mr. H was cognitively impaired. His short term memory was impaired, and his memory recall was impaired. While he did not require professional nursing services to manage his cognitive impairment, his memory for events was sufficiently impaired that he could not recall events or names of close friends or relatives (code of 2); his memory and use of information was sufficiently impaired that he had "difficulty remember and using information" and required "direction and reminding from others four or more times per day" (code of 3); he was periodically confused during the daytime (code of 2); he was, however, spatially oriented (code of 0), and he had minor difficulty with verbal communication (code of 1). As a result, he received a total cognitive score of 8.[8]
- Mr. H displayed behavior issues. He had difficulty with wandering. While he did not require professional nursing services to manage his behavior issues, his behavior issues during the week preceding the assessment were such that his sleep patterns were disturbed so that he was up wandering "for all or most of the night" (code of 4); he wandered inside the ALH and might wander outside, but his health and safety were not jeopardized (code of 2); his behavioral demands did not limit his living arrangement and companions (code of 0); he was not disruptive or aggressive (code of 0); while he frequently had difficulty understanding his needs, he cooperated when he was "given direction or explanation" (code of 2). As a result, he received a total behavior score of 8.[9]

When the scoring on Mr. H' 2012 CAT was totaled, his physical care needs and his cognitive and behavioral needs did not rise to the level where he continued to be eligible for

5 Ex. E, pp. 6 - 7, 9.
6 Ex. E, p. 9.
7 Ex. E, pp. 13 – 15.
8 Ex. E, pp. 16 – 17.
9 Ex. E, pp. 18 – 19.

Waiver services.[10] Mr. Cornell testified in support of his assessment, as recorded on the CAT. He exhibited no bias and was a credible witness regarding his own observations and his reports of what others told him. However, he had limited opportunity to observe Mr. H.

B P is the owner/administrator of the ALH where Mr. H resides. She has known him since he was admitted, which was almost five years ago, and is familiar with his condition. She does not reside in the ALH but is there multiple times each week. Her testimony disagreed with the assessment, as reflected on the 2012 CAT, of Mr. H' physical care needs and his cognitive and behavioral impairments as follows:

- She generally disagreed with the assessment of Mr. H' physical care needs, due to his need for ongoing monitoring and supervision.[11] However, she did not dispute that he did not require either limited one person physical assistance or extensive one person physical assistance in the categories of bed mobility, transfers, locomotion, and eating.
- She agreed that Mr. H required limited one person assistance with toileting.
- In her view, Mr. H' cognition is impaired to the point where he requires continual prompting for all of his activities. He has total memory failure, has no memory for events, and that category should have been coded as a 3 ("[c]annot recall entire events or name of spouse or other living partner even with prompting"). For instance, he does not remember Ms. P's name all of the time, and while he has a roommate, he does not refer to him by name, but instead as "roommate." His memory and use of information category should have been coded as a 4 because he requires continual prompting. In the category of global confusion, he should have been coded with a 3 because he is confused constantly, not only during the daytime. In the category of spatial orientation, he should have been coded with a 2 because he has a history of getting lost in his neighborhood. While he has not been lost in the neighborhood in over a year, it is because the ALH has alarms on the exits and he goes to adult daycare more frequently, which decreases his need to wander. In the category of verbal communication, he should have been coded with a 2 because he can only

[10] Ex. E, p. 31.

[11] For instance, Ms. P testified that while Mr. H is physically capable of bathing himself, his mental condition is such that he cannot bathe himself, and has to be physically assisted each time he bathes.

participate in simple conversations and cannot discuss anything beyond basics, and will often agree with a speaker because he cannot follow the discussion.

- Ms. P reported that Mr. H has substantial behavior problems. He was appropriately coded with a 4 in the sleep pattern category. He should have been coded with a 4 in the category of wandering due to a history of wandering and getting lost in the neighborhood, although he has not been lost in the neighborhood in over a year. While his behavior in the category of behavioral demands is currently a 1 ("[a]ttitudes, habits and emotional states limit the individual's type of living arrangement and companions") due to the fact that the staff has learned to deal with his behavioral demands, he should have been coded as a 3 ("[a]ttitudes, disturbances and emotional states create consistent difficulties that are modifiable to manageable levels. The consumer's behavior can be changed to reach the desired outcome through respite, in-home services, or existing facility staffing"). For instance, he requires roommate changes, and he goes through his roommate's belongings and staff purses looking for cigarettes. That behavior would occur almost daily except for the fact that the staff has learned to keep plenty of cigarettes available for him. He also urinates off the back deck and will disrobe. The staff keeps an eye on him and is able to deflect him. In the category of danger to himself and others, he should have been coded with a 2 ("[i]s sometimes (1 to 3 times in last 7 days) disruptive or aggressive, either physically or verbally") because he is both verbally and physically aggressive (yelling, shoving or bumping staff/roommate) at least once a week, on the average. She agreed that Mr. H was appropriately coded with a 2 in the category of awareness of needs/judgment.

Based upon her knowledge of Mr. H' care needs, her telephone demeanor, and her thoughtful answers to questions, Ms. P was a credible witness.

There is no evidence that Mr. H requires professional nursing intervention to address his cognitive or behavior patterns. There is also no evidence that Mr. H requires professional nursing services, therapy from a qualified therapist, specialized treatment, or therapies.

A registered nurse employed by Qualis Health, who was licensed in the State of the Alaska at the time of the review, performed a third-party document review of the Division's

determination that Mr. H was no longer eligible for Waiver services. That review concurred with the Division's determination.[12]

III. Discussion

A. Method for Assessing Eligibility

The Alaska Medicaid program provides Waiver services to adults with physical disabilities who require "a level of care provided in a nursing facility."[13] The purpose of these services is "to offer a choice between home and community-based waiver services and institutional care."[14]

The nursing facility level of care[15] requirement is determined in part by an assessment which is documented by the CAT.[16] The CAT records an applicant's needs for professional nursing services, therapies, and special treatments,[17] and whether an applicant has impaired cognition or displays problem behaviors.[18] Each of the assessed items is coded and contributes to a final numerical score. For instance, if an individual required 5 days or more of therapies (physical, speech/language, occupation, or respiratory therapy) per week, he or she would receive a score of 3.[19]

The CAT also records the degree of assistance an applicant requires for activities of daily living (ADL), which include five specific categories: bed mobility (moving within a bed), transfers (i.e., moving from the bed to a chair or a couch, etc.), locomotion (walking or movement when using a device such as a cane, walker, or wheelchair) within the home, eating, and toilet use, which includes transferring on and off the toilet and personal hygiene care.[20]

If a person has a self-performance code of 2 (limited assistance, which consists of non-weight bearing physical assistance three or more times during the last seven days, or limited assistance plus weight-bearing assistance one or two times during the last seven days) or 3 (extensive assistance, which consists of weight-bearing support three or more times during the past seven days, or the caregiver provides complete performance of the activity during a portion of the past seven days), plus a support code of 2 (physical assistance from one person) or 3

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12 Ex. D, p. 2.
13 7 AAC 130.205(d)(1)(B) and (d)(2).
14 7 AAC 130.200.
15 *See* 7 AAC 130.205(d)(2); 7 AAC 130.230(b)(2)(A).
16 7 AAC 130.230(b)(2)(B).
17 Ex. E, pp. 13 – 15.
18 Ex. E, pp. 16 - 17.
19 Ex. E, p. 31.
20 Ex. E, p.18.

(physical assistance from two or more persons), that person receives points toward his or her total eligibility score on the CAT. A person can also receive points for combinations of required nursing services, therapies, impaired cognition (memory/reasoning difficulties), or difficult behaviors (wandering, abusive behaviors, etc.), and required assistance with the five specified activities of daily living.[21]

In order for a person who only has physical assistance needs to score as eligible for Waiver services on the CAT, he or he would need a self-performance code of 3 (extensive assistance) or 4 (total dependence) and a support code of 2 or 3 for three or more of the five specified activities of daily living (bed mobility, transfers, locomotion within the home, eating, and toileting).[22]

The results of the assessment portion of the CAT are then scored. If an applicant's score is a 3 or higher, the applicant is medically eligible for Waiver services.[23]

B. Eligibility

It is undisputed that Mr. H does not require professional nursing services, therapy from a qualified therapist, specialized treatment, or therapies. It is undisputed that he does not require professional nursing intervention to manage either his impaired cognition or his behavioral problems. It is undisputed that he is neither totally dependent (self-performance code of 4) for nor requires extensive one person physical assistance (self-performance code of 3, support code of 2) with any of the five specified activities of daily living (bed mobility, transfers, locomotion within the home, eating, and toileting). As a result, Mr. H does not qualify for Waiver services for these reasons.

It is undisputed that Mr. H requires limited one person physical assistance with only one of the five specified activities of daily living, specifically toileting. While that need, by itself, would not qualify him for Waiver services, it would qualify him if he also had a total cognitive impairment score of 13 or more and a total behavior score of 14 or more.[24] Mr. H unquestionably exhibits substantially impaired cognition and difficult behaviors. The scoring on each of these is examined below.

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21 Ex. E, p. 31.
22 Ex. E, p. 31.
23 Ex. E, p. 31.
24 Ex. E, p. 31 – Scoring Questions NF. 3 – 7.

1. Cognition

The 2012 assessment, as reflected on the CAT, gave Mr. H a total cognition score of 8.[25] Ms. P's testimony disagreed. It must be noted that the Division's assessor and Ms. P were both credible witnesses. Ms. P's scoring would have provided Mr. H with a total cognition score of 14. In evaluating Mr. H' total cognitive score, it is necessary to consider that cognition is measured for the seven day period preceding the assessment: "enter the code that most accurately describes the person's cognition for last 7 days."[26]

In the subcategory of "Memory For Events," the Division coded Mr. H with a 2. Ms. P coded him with a 3. Ms. P's testimony that Mr. H could not remember her name all the time, despite having been in her ALH for approximately five years, and did not even use his roommate's name but merely referred to him as "roommate" supports a finding that this subcategory should have been coded with a 3, "[c]annot recall entire events or name of spouse or other living partner even with prompting" instead of with a 2, "[c]annot recall entire events (e.g. recent outings, visits of relatives or friends) or names of close friends or relative without prompting."[27]

In the subcategory of "Memory And Use of Information," the Division coded Mr. H with a 3. Ms. P coded him with a 4. Ms. P's testimony that he required continual prompting supports a finding that this subcategory should have been coded with a 4, "[c]annot remember or use information. Requires continual verbal reminding" rather than a 3, "[h]as difficulty remember and using information. Requires direction and reminding from others four or more times per day. Cannot follow written instructions."[28]

In the subcategory of "Global Confusion," the Division coded Mr. H with a 2. Ms. P coded him with a 3. Ms. P's testimony that he was constantly confused not just during the daytime, along with the fact that he is up most of the night,[29] supports a finding that this subcategory should have been coded with a 3, "[n]early always confused, rather than a 2, [p]eriodic confusion during daytime."[30]

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[25] Memory for Events 2; Memory and Use of Information 3; Global Confusion 2; Spatial Orientation 0; Verbal Communication 1. *See* Ex. E, p. 17.

[26] Ex. E, p. 17.

[27] Ex. E, p. 17.

[28] Ex. E, p. 17.

[29] The Division coded Mr. H with a 4 for greatly impaired sleep patterns: "[u]p wandering for all or most of the night, inability to sleep." Ex. E, p. 19.

[30] Ex. E, p. 17.

In the subcategory of "Spatial Orientation," the Division coded Mr. H with a 0. Ms. P coded him with a 2. A 2 would require him to get lost when walking his neighborhood.[31] Ms. P, however, testified that he had not gotten lost in the neighborhood in over a year. In order to qualify for a code of 2, being lost in the neighborhood would require that it have happened within the 7 day period immediately prior to the assessment.[32] Ms. P testified that he would wander in the neighborhood but for the ALH's remedial efforts (alarms on the exits and increased daycare). However, the CAT does not recognize remedial efforts when assigning a code for Spatial Orientation, merely whether the recipient had gotten lost in the neighborhood within the past seven day period.[33] Consequently, because it is undisputed that Mr. H had not gotten lost in the neighborhood for over a year, he would not receive a code of 2 in this category, regardless of whether he would wander and get lost without the ALH's remedial efforts. There was no evidence that Mr. H should have been coded with a 1, that he experienced "[s]patial confusion when driving or riding in local community."[34] The evidence therefore supports a finding that the Division appropriately coded Mr. H with a 0 in this area.

In the subcategory of "Verbal Communication," the Division coded Mr. H with a 1. Ms. P coded him with a 2. Ms. P's testimony that Mr. H could only participate in simple conversations supports a finding that Mr. H should have been coded with a 2 because he is only "[a]ble to carry out simple conversations" as compared to a 1 ("[m]inor difficulty with speech or word-finding difficulties").[35]

The findings above are based upon the fact that Ms. P was a credible witness with extensive (approximately five years) experience of dealing with Ms. H. As a result, her testimony was given more weight than that of Mr. Cornell, who had limited interaction with Mr. H. As a result, it is more likely true than not true that Mr. H should have received a total cognitive score of 12.[36] In order for Mr. H to obtain a scoring point on the CAT for his cognitive impairment, he would have to have a total cognitive score of 13 or higher.[37] Because his

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31 Ex. E, p. 17.

32 Ex. E, p. 17.

33 In contrast, the behavior subcategory Behavioral Demands on Others explicitly provides for a higher code of 3 instead of 1, when the recipient displays difficult behaviors that are "modifiable to manageable levels" by the facility. *See* Ex. E, p. 19.

34 *See* Ex. E, p. 17.

35 *See* Ex. E, p. 17.

36 Memory for Events 3; Memory and Use of Information 4; Global Confusion 3; Spatial Orientation 0; Verbal Communication 2.

37 Scoring Question NF. 3. *See* Ex. E, p. 31.

cognitive score, adjusted as discussed above, was 12, he does not receive a scoring point on the CAT.

2. Problem Behaviors

The 2012 assessment, as reflected on the CAT, gave Mr. H a total behavior score of 8.[38] Ms. P agreed Mr. H was correctly coded with a 4 in the subcategory of Sleep Patterns, and with a 2 in the Awareness of Needs/Judgment subcategory. Ms. P disagreed with the coding in the remaining three behavior subcategories: Wandering, Behavioral Demands on Others, and Danger to Self and Others. Ms. P's coding would have provided Mr. H with a total behavior score of 15.[39] In evaluating Mr. H' total behavioral score, it is necessary to consider that behavioral problems are measured for the seven day period preceding the assessment: "enter the code that most accurately describes the person's behavior for last 7 days."[40]

In the disputed subcategory of Wandering, the Division gave Mr. H a code of 2 ("[w]anders within the facility or residence and may wander outside, but does not jeopardize health and safety").[41] While Ms. P disputed that code and felt it should have been a 4 ("[w]anders outside and leaves grounds. Has consistent history of leaving grounds, getting lost or being combative about returning. Requires a treatment plan that may include the use of psychotropic drugs for management and safety"[42]), it is undisputed that Mr. H has not wandered outside the home in over a year. In order for Mr. H to qualify for a code of 4 in this area, he would have had to have wandered outside the home within the 7 day period preceding the assessment. Ms. P's testimony raised the same argument with regard to the Wandering subcategory as was raised in the behavioral Spatial Orientation subcategory, *i.e.*, whether the ALH's remedial efforts that prevent wandering should be recognized and reflected in the coding. The CAT, however, does not recognize remedial efforts when assigning a code for Wandering, rather whether the recipient had gotten lost in the neighborhood within the past seven day

[38] Sleep Patterns 4; Wandering 2; Behavioral Demands on Others 0; Danger to Self and Others 0; Awareness of Needs/Judgment 2. *See* Ex. E, p. 19.
[39] Sleep Patterns 4; Wandering 4; Behavioral Demands on Others 3, Danger to Self and Others 2; Awareness of Needs/Judgment 2.
[40] Ex. E, p. 19.
[41] Ex. E, p. 19.
[42] Ex. E, p. 19.

period.[43] As a result, the undisputed evidence supports a finding that the code of 2 was appropriate.

In the disputed subcategory of Behavioral Demands on Others, the Division gave Mr. H a code of 0 ("[a]ttitudes, habits and emotional states do not limit the individual's type of living arrangement and companions"). Ms. P testified it should have been a 3 ("[a]ttitudes, disturbances and emotional states create consistent difficulties that are modifiable to manageable levels. The consumer's behavior can be changed to reach the desired outcome through respite, in-home services, or existing facility staffing").[44] Ms. P's testimony demonstrated that Mr. H exhibited problem behaviors: roommate issues, going through people's belonging, urination off the back deck, disrobing, which are controlled through his current services and staff training. This factual pattern squarely meets the definition used for a code of 3. Consequently, Mr. H should have coded with a 3 for Behavioral Demands, and not the code of 0 assigned by the Division.

In the disputed subcategory of Danger to Self and Others, the Division gave Mr. H a code of 0 ("[i]s not disruptive or aggressive, and is not dangerous"). Ms. P testified it should have been a 2 ("[i]s sometimes (1 to 3 times in last 7 days) disruptive or aggressive, either physically or verbally, or is sometimes extremely agitated or anxious, even after proper evaluation and treatment").[45] Ms. P testified that that Mr. H is physically and verbally aggressive to other residents and staff at least once a week, on the average. He will bump or shove others in the ALH and be verbally aggressive at the same time. Ms. P's testimony supports a finding that Mr. H should have received a code of 2 in this area.

The findings above are based upon the fact that Ms. P was a credible witness with an extensive (approximately five years) experience of dealing with Ms. H. As a result, her testimony was given more weight than that of Mr. Cornell, who had limited interaction with Mr. H. As a result, it is more likely true than not true that Mr. H should have received a total behavioral score of 13.[46]

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[43] In contrast, the behavior subcategory Behavioral Demands on Others explicitly provides for a higher code of 3 versus 1, when the recipient displays difficult behaviors that are "modifiable to manageable levels" by the facility. *See* Ex. E, p. 19.

[44] *See* Ex. E, p. 19.

[45] *See* Ex. E, p. 19.

[46] Sleep Patterns 4; Wandering 2; Behavioral Demands on Others 3, Danger to Self and Others 2; Awareness of Needs/Judgment 2.

In order for Mr. H to obtain a scoring point on the CAT for his behavioral problems, he would have to have a total behavioral score of 14 or higher.[47] Because his behavioral score, adjusted as discussed above, was 13, he does not receive a scoring point on the CAT.

3. Final Scoring on the CAT

As discussed above, Mr. H was not entitled to receive a scoring point on the CAT for either his cognitive impairment or his problem behaviors. This means his total score on the CAT was 0. The minimum scoring necessary to be found eligible on the CAT is a 3.[48] As a result, Mr. H is not eligible for Waiver services.

C. Termination of Waiver Services

Before the Division may terminate Waiver services for a person who was previously approved for those services, Alaska Statue 47.07.045, enacted in 2006, requires that the Division must demonstrate that the recipient's condition has materially improved to the point that the recipient "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."[49] As discussed above, Mr. H' 2012 assessment shows that he is no longer eligible for Waiver Services, *i.e.*, his condition has materially improved, as the term is defined by statute.[50]

IV. Conclusion

Mr. H' condition has materially improved to the point that he no longer qualifies for Medicaid Waiver services. The Division's decision to terminate Mr. H' Waiver services is AFFIRMED.

DATED this 11th day of July, 2013.

Signed
Lawrence A. Pederson
Administrative Law Judge

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47 Scoring Question NF. 4 (b). *See* Ex. E, p. 31

48 Scoring Question NF. 7. *See* Ex. E, p. 31.

49 AS 47.07.045(b)(1) and (b)(3)(C).

50 AS 47.07.045 also requires that the Division's assessment showing material improvement must be "reviewed by an independent qualified health care professional under contract with the department." The parties stipulated that the Division complied with this requirement.

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 25th day of July, 2013.

By: *Signed*
Name: Lawrence A. Pederson
Title/Agency: Admin. Law Judge, DOA/OAH

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