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

In the Matter of:	)	
	)	
G N	)	OAH No. 14-2081-MDS
	)	Agency Case No.

DECISION

I. Introduction

The issue in this case is whether G N is entitled to receive certain hourly and daily respite services under the Medicaid Home and Community-Based Waiver Services program (waiver services program).[1] The Division of Senior and Disabilities Services (DSDS or Division) approved Mr. N's proposed initial Plan of Care (POC) as to chore services, escort services, home delivered meals services, installation and monitoring of a "lifeline" device, transportation services, seven units of daily respite services (DRS), and 1,080 units of hourly respite services. The Division denied, however, Mr. N's request for an additional seven units of daily respite services (DRS), and an additional 1,000 units of hourly respite services (HRS). The Division denied the additional daily and hourly respite services on the basis that Mr. N's proposed POC did not contain necessary information regarding his primary caregiver, and on the basis that he did not respond to a specific, pre-denial request that he provide that information.

This decision concludes that the Division was correct to deny some portion of the respite services at issue *based on the information it had at the time it originally acted on the proposed POC renewal*. However, through the hearing process, additional information was obtain which justifies some (but not all) of the services which were originally denied. Accordingly, a total of 1,394 units of hourly respite services, and nine units of daily respite services, are approved for the plan year at issue. The remaining 686 units of hourly respite services, and five units of daily respite services, are denied. The Division's determination is therefore affirmed in part and reversed in part.

II. Facts[2]

A. Mr. N's Medical Problems and Care Needs

Mr. N is 66 years old.[3] He is widowed and lives alone.[4] His primary medical diagnosis is seizure disorder. His secondary medical diagnoses are cerebrovascular disease with bilateral

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[1] All findings in this paragraph are based on Ex. D unless otherwise stated.

[2] To avoid duplication, discussion of some facts, specifically relevant to the legal issues raised, has been deferred until the discussion of those issues in Section III, below.

stenosis, diffuse cerebral volume loss, chronic obstructive pulmonary disease (COPD), congestive heart failure, coronary artery disease, difficult / labored breathing, gastroesophageal reflux disease (GERD), gout, hypertension, liver failure, and post-triple coronary bypass surgery (2010). Magnetic resonance imaging (MRI) performed in 2008 indicates that Mr. N has a mass in the right side of his brain. He has a protruding hernia and wears a back brace because of it. He also has a fractured humerus bone in his upper left arm which causes him a great deal of pain. Although several of Mr. N's medical problems could likely be resolved or improved through surgery, he is not considered a good candidate for surgery at this time, and so many of his medical problems are currently alleviated with pain medications. Mr. N must currently take about 13 different prescription medications.[5]

Mr. N lives in a first floor apartment within a multi-level apartment complex.[6] He has three adult children, but they live out-of-state. He has a number of friends in his small town, and he goes out to socialize with them three or four times per week when he feels well enough. He uses a four-wheeled walker to get around.

Mr. N's sister, T D, was previously his primary caregiver.[7] However, she had her own health problems, and she died in December 2014.[8] Since the death of his sister, Mr. N has been cared for primarily by L G, who is Mr. N's paid personal care assistant (PCA), and by J W, who acts as Mr. N's alternate or "relief" PCA.[9] Mr. N's goal is to live independently, in his own apartment, for as long as possible.

At hearing, Mr. N credibly testified in relevant part as follows:

1. His sister, T D, was previously his primary unpaid care provider, but she died in mid-December 2014.

2. L G is currently his primary paid care provider. She provides services for him Monday through Friday. His understanding is that she provides services to him under both the PCA program and the waiver services program.

3. J W provides services to him on weekends and when Ms. G is not available.

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3 All factual findings in this paragraph are based on Exs. E5 - E6 unless otherwise stated.
4 Ex. E8.
5 Exs. E7 - E8.
6 All factual findings in this paragraph are based on Exs. E7 - E9 unless otherwise stated.
7 All factual findings in this paragraph are based on Exs. E8 - E9 unless otherwise stated.
8 G N's hearing testimony.
9 G N's hearing testimony.

4. He has a seventh grade education, and does not understand the complexities of the Medicaid system.

At hearing, Mr. N's care coordinator, R S, testified in relevant part that:

1. She received an e-mail from Ms. Q in July 2014 requesting a care calendar. However, because this did not appear to be a prerequisite for obtaining respite services, she did not provide it.

2. Because Ms. D died only about one month prior to the hearing, she had not yet submitted a request to amend Mr. N's plan of care on this issue.

On the date of the hearing, Ms. S submitted a Division form, titled "Waiver Service Care Calendar," containing entries indicating care provided to Mr. N.[10] Of a total of 39 care entries, 33 entries are by J W, whose relationship to Mr. N is indicated as "friend," and the remaining six entries are by L G, whose relationship to Mr. N is indicated as "PCA." None of the pages or entries is dated.

B. Relevant Procedural History

Mr. N has received Medicaid Home and Community-Based Waiver services ("waiver services"), through the Alaskans Living Independently (ALI) waiver, since 2013 or before.[11] On May 5, 2014 Mr. N submitted his proposed annual / renewal POC for the period from April 17, 2014 through April 16, 2015.[12] Mr. N requested 2,080 units of Chore services, five units per week of Escort services, 14 units per week of Home Delivered Meals services, installation and 12 units of Lifeline services, 5 units per week of Transportation services, 2,080 units of Hourly Respite services (HRS), and 14 units of Daily Respite services (DRS).[13]

On October 13, 2014 the Division issued a letter approving Mr. N's POC in part and denying it in part.[14] The Division approved Mr. N's renewal POC as to 2,080 units of Chore services, five units per week of Escort services, 14 units per week of Home Delivered Meals services, installation and 12 units of Lifeline services, 5 units per week of Transportation services, 1,080 units of Hourly

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[10] This document was submitted by Ms. S as Ex. 2, but has been re-designated here as Ex. 1.

[11] The Division's letter dated October 13, 2014 states that the POC received on behalf of Mr. N on May 5, 2014 was an *initial* POC. At hearing, however, Ms. S stated that the POC at issue here is actually a *renewal* POC, and that Mr. N's prior POC provided him with 2,080 units of hourly respite services, and 14 units of daily respite services. On my inquiry, the Division's hearing representative agreed that this was the case. Accordingly, in this case, the Division is not denying new, additional services (in which case the recipient, Mr. N, would bear the burden of proof). Rather, the Division is reducing the amount of Mr. N's existing respite services by approximately 50%. Accordingly, the Division bears the burden of proof on all factual issues in this case.

[12] Exs. E2 - E23.

[13] Ex. D; Ex. 4 pages 11 - 15.

[14] All findings in this paragraph are based on Ex. D unless otherwise stated.

Respite services, and 7 units of Daily Respite services.[15] The Division denied Mr. N's renewal POC as to 1,000 units of Hourly Respite services, and seven units of Daily Respite services.[16] The Division's stated basis for denying the portion of the respite services at issue was that the POC renewal did not sufficiently clarify the unpaid primary caregivers' roles.[17]

On November 2, 2014 Mr. N and his care coordinator requested a hearing to contest the Division's determination.[18] Mr. N's hearing was held on January 15, 2015. Mr. N participated in the hearing by phone, represented himself, and testified on his own behalf. Mr. N's care coordinator, R S, participated in the hearing by phone and testified on Mr. N's behalf. The Division was represented by Tammy Smith, who participated in the hearing by phone. Program Manager C Q participated in the hearing by phone and testified on behalf of the Division. The record closed at the end of the hearing.

III. Discussion

A. Applicable Burden of Proof and Standard of Review

In this case, the Division did not deny new, additional services (in which case the recipient, Mr. N, would bear the burden of proof). Rather, the Division reduced the amount of Mr. N's existing respite services by approximately 50%. Accordingly, pursuant to applicable state and federal regulations, the Division bears the burden of proof on factual issues in this case.[19]

The standard of review in a Medicaid "Fair Hearing" proceeding, as to both the law and the facts, is *de novo* review.[20] In this case, evidence was presented at hearing that was not available to the Division's reviewers. The administrative law judge may independently weigh the evidence and reach a different conclusion than did the Division's staff, even if the original decision is factually supported and has a reasonable basis in law. Likewise, the Commissioner is not required to give deference to the factual determinations or legal interpretations of his employees or contractors.

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15 Ex. D1.

16 Ex. D2.

17 On July 7, 2014 the Division requested additional information from Mr. N's care coordinator in an effort to cure this informational deficiency, but no response was received by the Division (Ex. D2).

18 Ex. C.

19 42 CFR § 435.930, 7 AAC 49.135.

20 *See* 42 CFR 431.244; *Albert S. v. Dept. of Health and Mental Hygiene*, 891 A.2d 402 (2006); *Maryland Dept. of Health and Mental Hygiene v. Brown*, 935 A.2d 1128 (Md. App. 2007); *In re Parker*, 969 A.2d 322 (N.H. 2009); *Murphy v. Curtis*, 930 N.E.2d 1228 (Ind. App. 2010).

B. Medicaid Home and Community-Based Waiver Services Program - Overview

1. Relevant Federal Medicaid Statutes and Regulations

States participating in Medicaid must provide certain mandatory services.[21] States may also, at their option, provide certain additional services, one of which is the Home and Community-Based Waiver Services program.[22] Congress created the waiver services program to allow states to offer long-term care, not otherwise available through Medicaid, to serve recipients in their own homes and communities instead of in nursing facilities.[23] Federal regulations require that both mandatory *and* optional Medicaid services "be sufficient in amount, duration, and scope to reasonably achieve [their] purpose."[24] However, a state may "place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures."[25]

2. Relevant State Medicaid Regulations

The specific types of waiver services at issue in this case (*i.e.* daily and hourly respite services) are defined by regulation. The respite services regulation, 7 AAC 130.280, provides in relevant part as follows:

> (a) The department will pay for respite care services that (1) are approved under 7 AAC 130.217 as part of the recipient's plan of care; (2) receive prior authorization; and (3) do not exceed the maximum number of hours and days in (c) of this section.
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> (b) The department will consider services to be respite care services if they provide alternative caregivers, regardless of whether the services are provided in the recipient's home or at another location, to relieve (1) primary unpaid caregivers, including family members....
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> (c) The department will not pay for respite care services that exceed the following duration limits: (1) 520 hours of hourly respite care services per year, unless the lack of additional care or support would result in risk of institutionalization . . . . (2) 14 days of daily respite care services per year.

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[21] *See* 42 USC §§ 1396a(a)(10)(A); 1396d(a)(1) -(5), 1396a(a)(17), and 1396a(a)(21); *see also* 42 CFR 440.210 & 440.220.

[22] *See* 42 USC § 1396a(a)(10)(A). The program is called a "waiver" program because certain statutory Medicaid requirements are waived by the Secretary of Health and Human Services. *See* 42 USC 1396n(c).

[23] *See* 42 USC 1396n(c)(1); 42 CFR §§ 435.217; 42 CFR §§441.300 - 310. Federal Medicaid regulation 42 CFR 440.180, titled "Home or Community-Based Services," provides in relevant part:

> (a) Description and requirements for services. "Home or community-based services" means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of Part 441, subpart G of this chapter . . . .
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> (b) Included services. Home or community-based services may include the following services . . . (1) Case management services. (2) Homemaker services. (3) Home health aide services. (4) Personal care services. (5) Adult day health services. (6) Habilitation services. (7) Respite care services. (8) Day treatment . . . (9) Other services requested by the agency and approved by CMS *as cost effective and necessary to avoid institutionalization*. [Emphasis added].

[24] 42 CFR 440.230(b).

[25] 42 CFR 440.230(d); *see also DeLuca v. Hammons*, 927 F. Supp. 132 (S.D.N.Y.1996).

(d) The department will pay under this section for respite care services subject to the following limitations . . . . (4) the department will not pay for respite care services to (A) allow a primary caregiver to work; (B) relieve other paid providers of Medicaid services, except providers of family home habilitation services . . . .
. . . .

(f) In this section . . . (1) "daily respite care services" means respite care services no less than 12 and no more than 24 hours in duration . . . .

7 AAC 130.319(9) defines "primary caregiver" as:

[A]n individual (A) that lives in (i) the same unlicensed residence as a recipient and provides care for a recipient; or (ii) a different residence and provides care for a recipient in the recipient's unlicensed residence; and (B) assists with or provides the care described as activities of daily living in 7 AAC 125.030(b) and instrumental activities of daily living in 7 AAC 125.030(c) . . . .

The information which must be submitted in support of a Plan of Care, and the standards for their approval, are specified by 7 AAC 130.217, which provides in relevant part as follows:

(b) The department will approve a plan of care if the department determines that

(1) the services specified in the plan of care are sufficient to prevent institutionalization and to maintain the recipient in the community;

(2) each service listed on the plan of care (A) is of sufficient amount, duration, and scope to meet the needs of the recipient; (B) is supported by the documentation required in this section; and (C) cannot be provided . . . except as a home and community-based waiver service under this chapter . . . .

The issues in this case concern whether Mr. N's Plan of Care satisfies the requirements of the portions of 7 AAC 130.217, 7 AAC 130.280, and 7 AAC 130.319(9), above.

C. Is Mr. N Entitled to Additional Respite Services?

The bases for partial denial of Mr. N's Plan of Care are limited to those expressed in the Division's notice of September 4, 2014.[26] A fair reading of the Division's notice of adverse action

[26] *See Algonquin Gas Transmission Company v. FERC*, 948 F.2d 1305, 1312 n. 12 (D.C.Cir.1991) (an administrative determination "must stand or fall on the grounds articulated by the agency" in that determination); *In Cherokee Nation of Oklahoma v. Norton*, 389 F.3d 1074, 1078 (10th Cir. 2004*), cert. denied*, 546 U.S. 812, 126 S.Ct. 333, 163 L.Ed.2d 46 (2005), (agency action must be upheld, if at all, on the basis articulated by the agency); *American Textile Manufacturers Institute, Inc. v. Donovan*, 452 U.S. 490, 539, 101 S.Ct. 2478, 69 L.Ed.2d 185 (1981) (an agency's *post hoc* rationalizations are an insufficient basis for agency action); 2 Charles H. Koch, Jr., *Administrative Law & Practice* § 8.22 (2nd Edition 1997) ("[t]he number of cases rejecting agency efforts to justify actions after the fact shows the strength of the prohibition against *post hoc* rationalization"); *compare* 42 CFR 431.241(a) (only matters to be considered at a Medicaid hearing are those pertaining to the agency's action).

in this case indicates that its basis for denying the portion of the respite services at issue was that the POC renewal did not sufficiently clarify the unpaid primary caregivers' roles.[27]

In order to determine whether an applicant or recipient is entitled to respite services, 7 AAC 130.217(b)(2)(B), 7 AAC 130.280(b), and 7 AAC 130.319(9) cumulatively require that the Division confirm the identity of the primary unpaid caregiver, and confirm that he or she assists the applicant / recipient with his or her activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The Division was entitled to seek and require the information necessary to do this during the POC renewal process.[28]

Mr. N's POC stated his reasons for requesting respite services as follows:[29]

> Due to [a] decline in [Mr. N's] health, [and his] recent falls and ever-increasing medical intervention[s], [his] sister and friends are overwhelmed with [his] care needs at times. The respite providers will be selected by [Mr. N] in conjunction with the primary care provider and will be trained by primary care providers. Respite providers will assist [Mr. N] with all areas of activities of daily living as required, general health care needs, nutritional needs, and participat[ion] in social and recreational activities at home and in the community.
> Expected outcome[s]: Provide respite for sister T D.

This description indicates *why* Mr. N needs respite services, and identifies the unpaid caregiver who would actually *receive* the respite. On the other hand, it does not specify why the *specific amounts* of respite care requested are needed.[30]

The extent of a recipient's need for respite services depends on the extent to which the recipient's unpaid caregiver is tied-down providing care for the recipient. Accordingly, in making determinations about respite care, the Division is entitled to request information as to how often services are provided by the primary unpaid caregiver, as opposed to how often (and what kind) of services are provided by paid PCAs and/or waiver services providers.

Ms. Q testified that, when she was processing Mr. N's renewal POC, she had asked, via e-mail, that Ms. S send her a completed "care calendar" form so that she could verify the identity of

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[27] Ex. D2.

[28] Ideally, the Division's POC form should be more specific about the exact information required to obtain each form of waiver service requested. However, even though the Division's current POC form may not specifically ask for a particular item of information, the Division may still request additional information so long as (1) the information requested is indeed relevant under the applicable regulation; (2) the Division gives the recipient a reasonable amount of time to submit the additional requested information; and (3) the Division does not request information arbitrarily.

[29] Ex. E12.

[30] It should be noted that the Division *had previously approved* the amount of respite requested in the renewal POC at issue. Accordingly, it would not be unreasonable for a care coordinator to conclude, under those circumstances, that the necessity of the particular amount of services requested had already been established through the *prior* POC.

Mr. N's primary caregiver.[31] Ms. Q testified that the calendar was not provided, and so she denied a portion of the respite services requested.[32]

Ms. S did not dispute that she failed to provide the Division with the requested care calendar prior to hearing. She stated, however, that she did not feel she needed to provide a care calendar because it is not specifically required by regulation.[33]

It is true that there are no state or federal regulations which specifically require the completion of a care calendar, *per se*, in order to obtain respite services. However, the Division may certainly request completion of a care calendar *as a tool to obtain the information which is required by its regulations.* Since the care calendar form has not been adopted by regulation, the care coordinator could, if desired, provide the requested information *in another form*. However, the information must, if requested, be provided *somehow*. In this case, it is undisputed that the care calendar information requested by Ms. Q[34] was not provided prior to the Division's partial denial of the respite services. It is likewise undisputed that Ms. S did not request an extension of time to submit the care calendar or equivalent information. Accordingly, it was not incorrect for the Division to deny all or part of the respite services requested based on the information available to the Division as of October 13, 2014.[35]

However, this is a *de novo* proceeding, and additional information was obtained through Mr. N's testimony at hearing. By the end of the hearing, it was clear that Mr. N's sister, T D, had been the primary unpaid care provider from the start date of the POC at issue on April 17, 2014, through the time of her death in mid-December 2014, and was entitled to respite services during that eight month period (as she had been under the prior POC).

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[31] The renewal POC clearly indicates that T D was the primary unpaid caregiver (Ex. E12), but Ms. Q was entitled to verify this.

[32] Ms. Q was correct to do this. Technically, however, if Ms. Q felt that necessary information had not been provided, she should have denied *all* of the respite services requested, rather than just half of them.

[33] Tammy Smith, the Division's hearing representative, stated that the Division requires that a care calendar (1) cover one specified / dated 24 hour period during the week, and one 24 hour specified period on a weekend; (2) show the services provided by all paid and unpaid caregivers on that date; and (3) be signed by the recipient and by all paid and unpaid caregivers.

[34] Ms. Smith stated at hearing that previously, if the Division reviewed an applicant's or recipient's POC and found it to be incomplete, the Division would send out a notice of insufficiency, giving the applicant / recipient an opportunity to cure the alleged insufficiency. Ms. Smith also stated that the Division had suspended this practice during the period at issue in this case. In this case, however, Ms. Q' e-mail provided Ms. S with actual notice of the additional information sought by the Division.

[35] On the day of the hearing, Ms. S did provide a partially completed care calendar form. However, the completed portion of the calendar spanned less than three days, and the calendar was undated, so it is not known when the services were provided. Accordingly, this information, by itself, was not complete enough to allow for approval of all the respite care requested. Mr. N's hearing testimony did, however, supply some of the missing information.

On the other hand, by the end of the hearing, it was still not clear who was supposed to be receiving respite services, or who was supposed to be providing them, during the four month remainder of the plan year following the death of Ms. D (*i.e.* from mid-December 2014 through April 16, 2015).

In summary, the information obtained through the hearing process demonstrates that Mr. N is entitled to eight months' worth (two-thirds) of the total amount of respite care sought, but the Division was correct to deny the remaining four months' worth (one-third) of the total respite care sought. Accordingly, a total of 1,394 units of hourly respite services, and nine units of daily respite services, are approved for the plan year at issue. However, the remaining 686 units of hourly respite services, and five units of daily respite services, must be denied.

IV. Conclusion

The Division's denial of the respite services at issue was not incorrect based on the information available to the Division at the time it made its original determination. However, additional relevant information was obtained from Mr. N at hearing. This information demonstrates his eligibility for some, but not all, of the respite services which were originally denied. Accordingly, a total of 1,394 units of hourly respite services, and nine units of daily respite services, are approved for the plan year at issue. The remaining 686 units of hourly respite services, and five units of daily respite services, are denied. The Division's determination is therefore affirmed in part and reversed in part.

DATED this 30th day of June, 2015. *Signed*
Jay D. Durych
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 July, 2015.

By: *Signed*
Name: Jared C. Kosin, J.D., M.B.A.
Title: Executive Director
Agency: Office of Rate Review, DHSS

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