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

In the Matter of	)	
	)	
N D C	)	OAH No. 15-0470-MDS
	)	Division No.

DECISION

I. Introduction

N D C applied for Medicaid Home and Community-Based Waiver program (Waiver) services. She was assessed for eligibility on March 16, 2015. The Division of Senior and Disabilities Services (Division) denied her application on April 8, 2015,[1] and Ms. C requested a hearing.[2]

Ms. C's hearing took place on May 19, 2015. Ms. C was represented by her legal guardian and spouse, E C. U H, the owner and nurse-manager of the assisted living facility where Ms. C currently resides, also participated on Ms. C's behalf. Victoria Cobo represented the Division. Margaret Rogers, R.N, testified for the Division.

Ms. C experiences significant physical, cognitive and behavioral challenges related to her history of stroke, schizophrenia and dementia. However, Ms. C has not shown that her condition requires the nursing facility level of care that is required for Waiver eligibility. As a result, the denial of her application for Waiver services is upheld.

II. Facts[3]

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

N D C is 56 years old. Her medical diagnoses include epilepsy and recurrent seizures, diabetes mellitus, schizophrenia, dementia, hypertension and arthritis.[4] She has a history of stroke, also known as CVA or cerebrovascular accident, first occurring in 2006 and again in 2014. Her dementia appears to have worsened since her most recent stroke, and Ms. C displays both cognitive and behavioral impairment.

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1 Ex. D.

2 Ex. C.

3 These facts are based upon Ex. E, Claimant's Ex. 1 (E C letter, dated May 1, 2015), Claimant's Ex. 2 (Dr. K X diagnosis and recommendation, dated December 4, 2014), Claimant's Ex. 3 (Patient plan from Dr. A Z, dated Jan. 29, 2015), Claimant's Ex. 4 (assisted living facility nurse's notes dated January 11, 2015 to April 20, 2015), and the testimony of E C, U H, and Margaret Rogers.

4 Ex. E, p. 5, 23; Ex. 1, p. 4.

Ms. C was hospitalized for her second stroke in December 2014. On January 1, 2015, she moved into her present residence at Ms. H's assisted living facility. Ms. C uses a front-wheeled walker to get from place to place. She has an unsteady, shuffling gait, and she often has difficulty moving her left leg as she walks. She is at high risk of falling if moving around unsupervised, and she has a history of falls. Ms. C regularly needs guidance to maneuver around furniture or other obstacles in the house. Sometimes this means that someone moves furniture out of her way, since she often cannot figure out how to navigate around objects. Sometimes it means that someone puts a hand on her arm and guides Ms. C to a chair or to the appropriate destination.

Ms. C often communicates with one word statements, for instance "coffee" or "medicine."[5] However, she sometimes speaks in more complete sentences as well.[6] She is often awake and restless at night and she frequently wanders around the home. Ms. C is oriented to the environment in the assisted living home, but she requires verbal cues to remember most staff names. Ms. C has not accepted the assisted living facility as her new home, and she frequently expresses her desire to leave. The facility's nursing notes indicate that she routinely expresses anger or frustration, and she is often agitated or anxious. She can be quite unpleasant, yelling at caregivers, making faces or noises, and throwing temper tantrums. She has been known to pretend to fall down for attention, and she has pinched a staff member out of anger. She sometimes resists care by refusing her meals and medications. At the time of the assessment, Ms. C's problem behaviors could be redirected or ignored without use of medication until she settles down.[7]

Margaret Rogers, R.N., assessed Ms. C for Waiver eligibility on March 16, 2015. Ms. Rogers' conclusions regarding Ms. C's physical and mental function are documented on the Consumer Assessment Tool (CAT).

The assessment concludes in relevant part:

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[5] *See* Ex. 4, p.1 (nurse's notes).

[6] *See* Ex. 4, p. 5 ("No, I want to go to my home"), 7 (stated she is a troublemaker), 8 (screaming at staff in No Name Language).

[7] The issue in this case is whether Ms. C met the eligibility criteria for Waiver services at the time of her assessment, between March 16 and April 8, 2015. After the May 19, 2015 hearing in this matter, the evidentiary record closed. As a result, the undersigned cannot consider new evidence, such as the letter from Ms. C's doctor dated June 12, 2015. To the extent any new evidence would show that medication has been recently prescribed to manage Ms. C's behavior, this does not necessarily affect the analysis of Ms. C's care needs during the assessment period.

Nursing services, therapies, special treatments: Ms. C does not require professional nursing services or special treatments and therapies. She receives physical therapy one day per week.[8]

Cognition: Ms. C displays short-term memory problems. She could not draw a clock, and she could not recall three items in five minutes. She did not recall where she was on the date of the assessment. However, the assessment indicates that she knew the current season, the location of her room, and names or faces of caregivers. Her daily decision-making skills are rated "severely impaired." However, professional nursing assessment, observation or management is not required on either a weekly or a monthly basis to manage Ms. C's cognitive patterns.[9] Ms. C's total cognitive score was 0 out of a possible 16 on the cognition supplemental screening tool.[10]

Problem behaviors: Regarding problem behaviors, the assessment notes that Ms. C resists care one to three days per week, and her behavior is not easily altered.[11] However, her behavior does not require professional nursing assessment, observation or management on a weekly or monthly basis. The assessment does not note other behavioral problems, and Ms. C's total behavior score was 0.[12]

Activities of daily living:

Five activities of daily living (ADLs) are assessed as part of the Waiver eligibility process: bed mobility, transfers, locomotion (walking), eating and toileting.[13] The CAT summarized Ms. C's physical assistance needs and concluded that she requires limited assistance from one person with transfers and toileting (self-performance code 2, support code 2).[14] She requires supervision and setup help with locomotion and eating (self-performance code 1, support code 1), and she is independent with her bed mobility activities (self-performance code 0, support code 0).[15]

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8 Ex. E, pp. 7, 16.
9 Ex, E, p. 18.
10 Ex. E, p. 1.
11 Ex. E, p. 19.
12 Ex. E, p. 2.
13 Ex. E, p. 20 (shaded areas).
14 Ex. E, p. 20. Limited assistance includes physical help in the guided maneuvering of limbs or other nonweight-bearing physical assistance 3 or more times per week, or it may include those actions plus weight-bearing assistance 1 or 2 times per week.
15 Ex. E, p. 20. Supervision includes oversight, encouragement or cueing 3 or more times per week, or supervision plus nonweight-bearing physical assistance 1-2 times per week.

Ms. C submitted a detailed letter explaining her disagreement with a number of conclusions in the CAT. She disputes the assessment's conclusions about her physical assistance needs, particularly when those needs are viewed together with her cognitive and behavioral impairments. She argues that her total cognitive score should be 9, and her total problem behavior score should be 15. She also challenges the coding for her locomotion ADL, asserting that she requires limited assistance from one person for that activity (self-performance code 2, support code 2).

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."[16] The purpose of these services is "to offer a choice between home and community-based waiver services and institutional care."[17]

The nursing facility level of care[18] requirement is determined in part by an assessment which is documented by the CAT.[19] The CAT records an applicant's needs for professional nursing services, therapies, and special treatments,[20] and whether an applicant has impaired cognition or displays problem behaviors.[21] Each of the assessed items is coded and contributes to a final numerical score. For instance, if an individual requires 5 days or more of therapies (physical, speech/language, occupation, or respiratory therapy) per week, he or she would receive a score of 3.[22]

The CAT also records the degree of assistance an applicant requires for activities of daily living, 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 within the home (walking or movement using a device such as a cane, walker, or wheelchair), eating, and toilet use (which includes transferring on and off the toilet and personal hygiene care).[23]

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

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16 7 AAC 130.205(d)(1)(B) and (d)(2).
17 7 AAC 130.200.
18 *See* 7 AAC 130.205(d)(2); 7 AAC 130.230(b)(2)(A).
19 7 AAC 130.230(b)(2)(B).
20 Ex. E, pp. 15-17.
21 Ex. E, pp. 18-19.
22 Ex. E, p. 31.
23 Ex. E, p. 20.

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 (physical assistance from two or more persons), that person receives points toward her total eligibility score on the CAT.

A person also can 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.[24]

In order for a person who only has physical assistance needs to score as eligible for Waiver services on the CAT, he or she 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).[25]

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.[26]

B. Burden of Proof

Ms. C seeks Waiver services and bears the burden to prove by a preponderance of the evidence that she satisfies the eligibility requirements.[27] She can meet this burden using any evidence on which reasonable people might rely in the conduct of serious affairs.[28]

C. Eligibility

Waiver eligibility is determined by a point matrix set out in the CAT. As discussed previously, there are different ways to qualify. The various tests are abbreviated on the CAT summary scoring page as "NF.1, NF.2" and so on up to "NF.6."[29] Under NF.1, a person can qualify if any of the questions are answered "yes." Under the other tests, the scores are aggregated for a total nursing and ADL needs score, at NF.7. Ms. C sets out specific points of disagreement with the CAT's scoring of her needs, and the potential areas in which she could record eligibility points are addressed below.

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24 Ex. E, p. 31.
25 Ex. E, p. 31.
26 Ex. E, p. 31 (NF.7).
27 7 AAC 49.135.
28 2 AAC 64.290(a)(2).
29 Ex. E, p. 31

1. Eligibility Under NF.1

Ms. C would be automatically eligible for nursing facility level of care if any of the five questions in NF.1 on the assessment scoring page is answered "yes." The first four questions refer to her needs for professional nursing services or certain therapies. Listed professional nursing services include, for example, injections to treat an unstable condition, wound or catheter care, oxygen, professional nursing assessment for an unstable medical condition in which observation is required at least once every 8 hours, and care for an uncontrolled seizure disorder.[30] Qualifying therapies include the need for physical therapy, speech therapy, occupational or respiratory therapy at least five days a week.[31]

Ms. C does not require any of the listed nursing services. Her seizure disorder is considered controlled rather than uncontrolled, since her last seizure was somewhere between two and five years ago.[32] Her twice-weekly finger sticks to monitor blood glucose do not require the professional nursing skills identified in CAT Section A. Ms. C's weekly physical therapy also does not rise to the level necessary for automatic eligibility under NF.1(a) through NF.1(d).

A second way to establish automatic Waiver eligibility is through the fifth question in NF.1, which requires Ms. C to show that she needs extensive one person assistance (self-performance code 3, support code 2) with three or more of the five ADLs (eating, toileting, bed mobility, transfers, and locomotion). Of those ADLs, Ms. C disagrees only with the assessment's coding for her locomotion activities.[33] She asserts that she requires limited one person assistance. She does not argue that she requires extensive assistance with any of her ADLs, and the record would not support that conclusion.

Since she is not automatically eligible based on the analysis at NF.1, the CAT next looks to whether an applicant's impaired cognition or problem behaviors require a nursing facility level of care.[34] The parties agree that Ms. C requires limited assistance from one person for her transfer and toilet use ADLs. As a result, she would qualify for Waiver services if she also manifests acute cognitive or behavioral problems, which would credit her with one point under

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30 Ex. E, p. 31 (NF.1(a)-(c)).

31 Ex. E, p. 31(NF.1(d).

32 *See* Ex. E, p.5 (5 years ago); Testimony of Mr. C (2-3 years ago). *See also* Ex. 4, p.4 (nurse's note that seizures are controlled with medications managed by staff).

33 Ex. 1.

34 Ms. C does not record eligibility points under NF.2, since she does not require any of the listed nursing services, special treatments or therapies with the frequency that is required.

sections NF.3 or NF.4. Although her impairments in these areas are significant, they do not require a nursing facility level of care.

2. Eligibility Under NF.3 Based on Cognitive Impairment

To record an eligibility point under NF.3, Ms. C must answer "yes" to all four questions listed under that subsection of the CAT scoring page. She is able to answer "yes" to the first three questions, but does not do so on the last question.

Ms. C satisfies the first question under NF.3, since the assessment indicates that she experiences short-term memory problems.[35] The second question asks about the degree of her memory or recall impairment; she qualifies on this issue only if she recalled no more than two of the four questions about the current season, the location of her room, the names/faces of caregivers, and where she is.[36] The assessment credits Ms. C with the ability to remember the current season, the location of her room, and the names/faces of caregivers, but not where she is.[37]

According to Mr. C, his wife knows the location of her room but is not aware of the season or most caregivers' names and faces. He indicated that she only can remember one staff member's name at her assisted living home, despite seeing at least three individuals on a daily basis. The staff nursing notes reiterate that Ms. C does not know the names of staff she sees every day.[38] Mr. C's letter also indicates that Ms. C often cannot recall the names of friends and relatives.

Mr. C and the staff at the assisted living home see Ms. C daily, and they are familiar with her abilities and deficits with a depth that is not possible during a single assessment visit. For this reason, the evidence is sufficient to conclude that, more likely than not, Ms. C normally is able to recall only 1 or 2 of the 4 tests for memory and recall ability. She can answer "yes" to the second question in NF.3.

Ms. C satisfies the third question in NF.3 because the assessment rates her cognitive skills for daily decision-making as "severely impaired." The fourth question has several parts. It first

[35] Ex. E, p.18 (Section C.1.a).
[36] *See* Ex E, p.31 NF. 3(b).
[37] Ex. E, p. 18 (Section C.2).
[38] Ex. 4, p. 1 (nurse's note dated March 19, 2015).

asks whether professional nursing assessment, observation and management are required at least three days a week to manage Ms. C's cognitive patterns.[39]

At the time of the assessment in March and April 2015, caregivers were able to manage Ms. C's cognitive deficits through cueing, reminders and redirection. Ms. C did not require medication, and there is no evidence of other professional nursing involvement to meet her cognitive needs.

Section NF.3 next sets out an alternate, two-part test. Ms. C meets the first element of the test, because she requires limited assistance from one person for one or more of the five ADLs assessed for Waiver eligibility. She does not meet the second element, however, because her total cognitive score on the supplemental screening tool is not 13 or higher.

The assessment's supplemental screening tool for cognition does not reflect that Ms. C has any notable cognitive deficits. This is shown by the codes of zero for each of the five areas that are assessed: Memory for Events, Memory and Use of Information, Global Confusion, Spatial Orientation, and Verbal Communication.[40]

Mr. C submitted credible evidence indicating that the assessment overlooked a number of Ms. C's memory, orientation and communication deficits. He asserts that: Ms. C is unable to recall entire events or names of close friends/relatives without prompting (Memory for Events code 2); she requires direction and reminding from others four or more times per day (Memory and Use of Information code 3); she consistently has nighttime confusion and awakening that can be disruptive to others (Global Confusion code 1); she gets confused riding in a car in the community, and she gets lost when walking outdoors and cannot identify her residence (Spatial Orientation code 1); and she can only communicate one-word statements to express herself (Verbal Communication code 2).[41]

Even if all of Mr. C's conclusions about his wife's cognitive state were adopted, however, Ms. C's total cognitive score would be 9. This does not meet the threshold of 13 that is necessary for a qualifying point under NF.3. Therefore, it is not necessary to make specific findings on this topic.

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39 *See* Ex. E, p.31 (NF.3(d), referring back to the cognitive assessment at section C.4A).

40 The supplemental screening tool for cognition is at Ex. E, p.1.

41 Ex. 1, pp. 1-2.

3. Eligibility under NF.4 based on Problem Behaviors:

The final potential means of Waiver eligibility in this case is explained at NF.4 of the CAT scoring page. Under this section, Ms. C first has to show that certain problem behaviors occur at least 4 days a week. These behaviors include: wandering, being verbally abusive, being physically abusive, or displaying socially inappropriate or disruptive behavior such as disruptive sounds, screams, or self-abusive acts.[42]

The evidence in the record shows that Ms. C wanders and is verbally abusive at least four days a week. Mr. C's testimony was that his wife never sleeps through the night, and she often wanders within the facility. He also testified that she is abusive towards staff daily, whether by yelling, making faces, or throwing other temper tantrums. The facility nurse's notes support these statements and are sufficient to conclude that Ms. C's wandering and verbally abusive behavior occurs four or more times per week.

The next question under Section NF.4 has several parts. It first asks whether professional nursing assessment, observation and management are required at least three days per week to manage Ms. C's problem behaviors. The assessment indicates that such care is not required, and this conclusion is supported by the record. The hearing testimony was that Ms. C can be redirected or coaxed out of her poor behavior, even though it may take some time for her to calm down. Sometimes her behavior can be ignored until her mood passes. When she wanders at night, the nurse's notes indicate that she eventually goes back to bed. When she is verbally abusive, agitated or even physically aggressive, she eventually settles down and cooperates with caregivers. At the time of the assessment, her behavior did not require intervention with prescribed medication.

Section NF.4(b) next sets out an alternate, two-part test that still may establish an eligibility point based on problem behaviors. Ms. C meets the first part of the test since she requires limited one person assistance for one or more of the five relevant ADLs. She does not satisfy the second part of the test, however, which requires a total behavior score of 14 or higher on the behavior supplemental screening tool.[43]

The assessment codes Ms. C with zeroes for every area of the behavior screening tool, meaning she does not display significant behavioral problems. According to Mr. C, Ms. C

[42] Ex. E, p. 31 (NF.4.a, referring back to CAT Section D at Ex. E, p. 19).
[43] The supplemental screening tool for behavior is at Ex. E, p. 2.

regularly exhibits a number of significant problem behaviors, and her total behavioral score should have been 15.[44] He asserts that: Ms. C is often awake and restless at night (Sleep Patterns code 3); she has a history of wandering outside and endangering herself, for instance by falling in puddles and not being able to get up (Wandering code 4); she demonstrates attitudes, disturbances and emotional states that create consistent difficulties that are modifiable to manageable levels with existing facility staffing (Behavioral Demands on Others code 3); she is sometimes aggressive or disruptive, physically and verbally, and she is sometimes anxious or agitated and not easily redirected (Danger to Self and Others code 2); and, she does not understand her self-care needs and will not cooperate even if given direction or explanation (Awareness of Needs/Judgment code 3).

The evidence in the record establishes that Ms. C frequently displays a number of problem behaviors. However, it does not support the conclusion that these behaviors result in a score of 14 or more. Regarding sleep patterns, Mr. C has shown that his wife is awake and restless every night. A nursing note dated March 23 reiterates this fact, stating that Ms. C's nighttime behavior "continues to be active," and she often moves between the living room and bedroom "several times throughout the night." She becomes agitated when attempts are made to redirect her to her room, so she is left to resolve on her own and she eventually returns to her room around 3 or 4 a.m.[45] Ms. C's "Sleep Patterns" score is appropriately rated 3 (restless, disturbed sleep, increased awakenings).

The evidence suggests that Ms. C's "Wandering" coding is appropriately a 2, meaning that she wanders within the facility, especially at night, and she may wander outside, but she does not jeopardize health and safety. Mr. C presented evidence that his wife's wandering did potentially jeopardize her safety when she lived with the family, since she sometimes wandered outside and fell. She also made repeated attempts to leave the house during the night. Since she moved into her current residence, however, there is no indication that Ms. C's wandering poses a threat to her health or safety.

Regarding "Behavioral Demands on Others," Ms. C's attitudes, disturbances and emotional states should be coded a 3 because, as discussed previously, she creates consistent difficulties that are modifiable to manageable levels, and her behavior can be changed to reach

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[44] Ex. 1, p. 2.

[45] Ex. 4, p. 2; *see also* Ex. 4, pp. 6-7 (January 11, 2015 entries regarding disturbed sleep and wandering).

the desired outcome with existing facility staffing. Ms. C clearly presents consistent behavioral demands on those around her. Her unpredictable behavior understandably has made her family reluctant to take her on outings from the facility. However, at the time of the assessment, the evidence is that she could be redirected, coaxed or even ignored until her attitude changed and she became more cooperative.

Regarding "Danger to Self and Others," Ms. C is properly rated a 2. She is frequently verbally or physically disruptive or aggressive, and she is regularly extremely agitated or anxious. She is verbally disruptive or aggressive more than four times per week, and the nurse's notes indicate that she gave a hard pinch to a staff member on April 10, 2015. However, at the time of the assessment, professional judgment was not required to determine when to administer prescribed medication. This means she cannot be coded with a 3 in this area.[46]

As to "Awareness of Needs/Judgment," the evidence is that Ms. C frequently has difficulty understanding her self-care needs, and this occurs four or more times per week. She still does not understand or accept her placement in assisted living, she is regularly oppositional, agitated, and verbally abusive. She has a history of refusing to eat, shower, or take her medications when she is angry, and she would not manage her medications or maintain proper hygiene without daily staff intervention.[47] However, she eventually will cooperate when given direction or explanation, even if this process sometimes requires time for her to settle down. This results in a code of 2.

The sum of these scores is 12. In order to receive a point towards the scoring for Waiver eligibility, Ms. C requires a behavior score of 14. Consequently, although Ms. C displays significant problem behaviors, her behaviors are not considered acute enough to qualify for a point towards Waiver eligibility.

4. Scoring for Ms. C's Locomotion Activity of Daily Living

Ms. C also challenges the assessment's conclusion that she requires supervision and setup help with her locomotion ADL (self-performance code 1, support code 1). She argues that her locomotion assistance needs are more accurately rated limited assistance from one person (self-

[46] Even if professional judgment was needed to determine when to administer prescribed medication to help manage Ms. C's disruptive or aggressive behavior as described in Ms. C's physician's post-hearing (June 12, 2015) statement, this would only justify one additional point on the behavioral screening tool. It would not change the outcome in this case.

[47] *See* Ex. 4.

performance code 2, support code 2). It is not necessary to resolve this question, since Ms. C's Waiver eligibility does not change under either outcome.

IV. Conclusion

The evidence supports the conclusion that assisted living facility level of care adequately meets Ms. C's health care needs. There is no dispute that Ms. C benefits from, and may require, the level of the service and continuing oversight offered at her current placement. The question for Waiver eligibility, however, is whether Ms. C's physical health care needs, in conjunction with her cognitive or behavioral condition, require a nursing home level of care, as it is measured by the Medicaid Waiver program. Ms. C did not establish that her care needs are sufficiently acute to qualify her for Medicaid Waiver services. The Division's decision to deny her application is upheld.

DATED this 10th day of July, 2015.

Signed
Lawrence A. Pederson
Administrative Law Judge

Adoption

The undersigned, by delegation from the Commissioner of Health and Social Services, adopts this Decision, under the authority of AS 44.64.060(e)(1), as the final administrative determination in this matter.

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

DATED this 24th day of July, 2015.

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

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