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

In the Matter of:	)	
	)	OAH No. 15-1514-MDS
M D	)	Agency No.
	)	

DECISION

I. Introduction

The issue in this case is whether there has been a material change in M D's condition since her initial assessment on April 15, 2015. Ms. D applied to participate in the Medicaid Home and Community-Based Waiver Services program (waiver services program), and an assessment was conducted on April 15, 2015.[1] The Division of Senior and Disabilities Services (DSDS or Division) determined, based on that assessment, that Ms. D does not require skilled or intermediate-level nursing care, or require extensive assistance with three or more designated ("shaded") activities of daily living (ADLs).[2] Accordingly, the Division denied Ms. D's application for waiver services, and Ms. D did not appeal the Division's determination.[3]

Ms. D subsequently filed a second application for waiver services on September 29, 2015.[4] The Division denied that application on November 10, 2015 on the basis that waiver services regulation 7 AAC 130.211 allows the Division to conduct only one screening or assessment in any 365-day period unless there has been a material change in the applicant's condition since the first assessment.[5] Ms. D appealed the Division's determination of November 10, 2015, asserting that her condition has in fact materially worsened since the April 15, 2015 assessment, and that she is therefore entitled to a new assessment prior to the end of the normal one-year waiting period.[6]

This decision concludes that, while Ms. D may or may not be eligible to receive waiver services at present, she has proven, by a preponderance of the evidence, her condition has materially changed since the assessment of April 15, 2015. Accordingly, Ms.

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1 Exhibit E.
2 Exhibit D; undisputed hearing testimony.
3 Undisputed hearing testimony.
4 Undisputed hearing testimony.
5 Ex. D1.
6 Ex. C; M D hearing testimony.

D is entitled to a new assessment pursuant to 7 AAC 130.211(c). The Division's determination, denying Ms. D a new assessment, is therefore reversed.

II. Facts

A. Ms. D's Medical Condition per her Medical Records[7]

Ms. D is 54 years old.[8] She lives alone in a single-level home.[9] She has a son who is a minor, but he currently cannot live with her because, due to her medical problems, she is unable to care for him herself.[10] Ms. D's medical diagnoses include anemia, attention deficit/hyperactivity disorder (ADHD), back pain, brachial neuritis, cataracts, cleft palate, cerebrovascular disease, cervicalgia, congestive heart failure, degenerative disc disease, depression, gastroesophageal reflux disease (GERD), goiter, hemangioma, hiatal hernia, hypertension, hyperthyroidism, irritable bowel syndrome (IBS), kyphosis, left shin hematoma, memory loss, myalgia, myositis, nephrolithiasis, osteoarthritis of the left hip and right knee, peptic ulcer disease, sciatica, spinal stenosis, and Stickler syndrome with associated chronic pain.[11] Ms. D suffers from left hip pain, right knee pain, abdominal pain, muscle spasms, soft-tissue swelling, fatigue, and malaise.[12] She takes at least fourteen prescription medications.[13]

Ms. D had back surgery in 2013.[14] In October 2014, Ms. D underwent a colonoscopy, an esophagogastroduodenoscopy (EGD), and colon resection surgery. Ms. D has also had a cholecystectomy, surgery to repair an abdominal aortic aneurysm, cataract surgery, cleft palate repair, stent placement, wrist surgery, and knee surgery.

On October 23, 2014 and December 17, 2014 Ms. D was seen for a sore on her right foot.[15] The nurse's notes from the later appointment state in relevant part as follows:

> Objective. Skin: No change . . . hadn't taken her socks off for a week. A single ulcer was seen, right foot, 2 x 2 cm. A circular ulcer spreading outward with a surrounding red ring was seen . . . on the top of the right foot, anterior aspect . . . which was deep . . . .

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7 Ms. D submitted approximately 100 pages of medical records in this case. All of those records were reviewed and considered during the preparation of this decision.

8 Exhibit 1 p. 2.

9 Exhibit 3 p. 4; Ex. E3; M D hearing testimony.

10 Exhibit 3 p. 4.

11 Exhibit 2 p. 6; Exhibit 3 pp. 2, 3, and 61; Exhibits E5, E6.

12 All factual findings in this paragraph are based on Exhibit 2 pp. 2 - 3 unless otherwise stated.

13 Exhibit 2 p. 1.

14 All factual findings in this paragraph are based on Exhibit 2 p. 4 and Ex. 3 pp. 2 -3 unless otherwise stated.

15 All factual findings in this paragraph are based on Exhibit 2 p. 5 and Ex. 5 p. 5 unless otherwise stated.

On June 26, 2015 Ms. D fell and was taken to a hospital emergency room.[16] She was found to have fractured her left hip[17] and was admitted to the hospital, where she remained from June 26, 2015 through July 21, 2015. She was found to have severe osteoarthritis of both hips, with complete loss of joint space, femoral head flattening, and significant subchondral cyst formation.[18] Surgery was performed on July 27, 2015 to repair the neck of her left femur.[19] Her recovery was complicated by chronic pain. After about one month she was transferred to the hospital's inpatient rehabilitation department, where she stayed from July 21, 2015 to August 5, 2015. As of August 25, 2015, she was found to be able to use the toilet with supervision, to be able to bathe with stand-by assistance; and to be able to walk down stairs with crutches and a contact guard. Finally, Ms. D was found to require assistance with cleaning, grocery shopping, and laundry.

On July 18, 2015, an MRI was taken of Ms. D's lumbar spine.[20] The MRI revealed focal kyphosis, moderate to severe central canal stenosis, posterior disc protrusion, disc desiccation, and a small annular fissure at T12-L1.

On January 25, 2016, Ms. D underwent a physical therapy assessment.[21] The assessment found Ms. D's mobility to be at least 80% impaired, and recommended that she undergo physical therapy three times per week for eight weeks.

B. Relevant Procedural History

Ms. D first applied for participation in the waiver services program at some time prior to April 2015.[22] In response to that application, on April 15, 2015 Mary Tanaka, R.N. (a nurse-assessor employed by the Division) conducted an assessment of Ms. D's eligibility for the waiver services program.[23] Ms. Tanaka used the Division's Consumer Assessment Tool or "CAT,"[24] a document described in detail in Section III, below. Ms. Tanaka found that, at that time, Ms. D did not require a nursing facility level of care, or extensive

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16 All factual findings in this paragraph are based on Exhibit 1 p. 2 and Ex. 3 pp. 67, 70, and 71 unless otherwise stated.
17 Ex. 3 pp. 51 - 52.
18 Ex. 3 p. 8.
19 Ex. 3 p. 50.
20 All factual findings in this paragraph are based on Exhibit 3, pp. 48, 49, 62, and 66 unless otherwise stated.
21 All factual findings in this paragraph are based on Exhibit 7, pp. 1 - 3 unless otherwise stated.
22 Uncontested hearing testimony.
23 Exhibit E.
24 Exhibit E.

assistance with three or more "shaded" ADLs, and therefore concluded that Ms. D was not then eligible for the waiver services program.[25]

On September 29, 2015, Ms. D reapplied for waiver services.[26] On November 10, 2015, the Division notified Ms. D that it would not be performing a new assessment because, pursuant to its regulations, an applicant is entitled to only one assessment for waiver services per year, "unless a change in condition has occurred that would reasonably support requesting an early assessment."[27] The Division's notice further stated that, although the Division had reviewed certain additional medical records submitted by Ms. D, those medical records did not demonstrate a change in condition sufficient to warrant the granting of a new assessment prior to the expiration of the one-year waiting period.[28] Accordingly, the Division's prior denial of waiver services would remain in effect.

On November 17, 2015, Ms. D requested a hearing to contest the Division's denial of her application for waiver services.[29] Ms. D's hearing was held on January 28, 2016. Ms. D attended the hearing, represented herself, and testified on her own behalf. She was assisted by her friend S H, who attended the hearing and testified on Ms. D's behalf. T N, Ms. D's care coordinator, participated in the hearing by phone but did not testify. The Division was represented by Medical Assistance Administrator Laura Baldwin. Mary Tanaka, R.N. attended the hearing and testified on the Division's behalf. The record closed at the end of the hearing.

III. Discussion

A. Applicable Burden of Proof and Standard of Review

Pursuant to applicable state and federal regulations, Ms. D, as applicant, bears the burden of proof in this case.[30] The standard of review in a Medicaid "Fair Hearing" proceeding, as to both the law and the facts, is *de novo* review.[31] In this case, evidence was presented at hearing that was not available to the Division's reviewers. The administrative

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25 Exhibits E32 - E33.
26 Exhibit D1; uncontested hearing testimony.
27 Exhibit D1.
28 Exhibit D1.
29 Exhibit C.
30 42 CFR § 435.930, 7 AAC 49.135.
31 *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).

law judge (ALJ) 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.

B. Relevant Alaska Medicaid Statutes and Regulations

States participating in the Medicaid program must provide certain mandatory services under the state's medical assistance plan.[32] States may also, at their option, provide certain additional services, one of which is the Home and Community-Based Waiver Services program[33] ("waiver services").[34] Congress created the waiver services program in 1981 to allow states to offer long-term care, not otherwise available through the states' Medicaid programs, to serve eligible individuals in their own homes and communities instead of in nursing facilities.[35] Alaska participates in the waiver services program.[36]

There are three basic ways in which an applicant or recipient can qualify for waiver services. First, an individual is eligible for waiver services if he or she requires the level of care specified in 7 AAC 130.205. For older adults and adults with disabilities (such as Ms. D), that level of care must be either "intermediate care" as defined by 7 AAC 140.510, or

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

[33] The program is called a "waiver" program because certain statutory Medicaid requirements are waived by the Secretary of Health and Human Services. *See* 42 U.S.C. § 1396n(c). Before a state receives federal funding for the program, the state must sign a waiver agreement with the United States Department of Health and Human Services. *Id.* The agreement waives certain eligibility and income requirements. *Id.*

[34] *See* 42 USC § 1396a(a)(10)(A).

[35] *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].

[36] AS 47.07.045, the Alaska statute that authorizes Medicaid Waiver Services, states in relevant part:

> Home and community-based services. (a) The department may provide home and community-based services under a waiver in accordance with 42 USC 1396 – 1396p (Title XIX Social Security Act), this chapter, and regulations adopted under this chapter, if the department has received approval from the federal government and the department has appropriations allocated for the purpose. To supplement the standards in (b) of this section, the department shall establish in regulation additional standards for eligibility and payment . . . .

"skilled care" as defined by 7 AAC 140.515.[37] Intermediate care, a lower level of care than skilled care, is defined by 7 AAC 140.510 in relevant part as follows:

> (a) The department will pay an intermediate care facility for providing the services described in (b) and (c) of this section if those services are (1) needed to treat a stable condition; (2) ordered by and under the direction of a physician, except as provided in (c) of this section; and (3) provided to a recipient who does not require the level of care provided by a skilled nursing facility.
>
> (b) Intermediate nursing services are the observation, assessment, and treatment of a recipient with a long-term illness or disability whose condition is relatively stable and where the emphasis is on maintenance . . . .
>
> (c) Intermediate care may include occupational, physical, or speech-language therapy provided by an aide or orderly under the supervision of licensed nursing personnel or a licensed occupational, physical, or speech-language therapist.

The Division is required to incorporate the results of the CAT in determining whether an applicant requires intermediate or skilled nursing care.[38]

The second way an individual may qualify for waiver services is by showing that the individual's requirements for physical assistance with his or her activities of daily living (ADLs) are sufficiently high.[39] Under the CAT, an individual can qualify for waiver services by demonstrating a need for extensive assistance with at least three of the five ADLs used in waiver eligibility determinations, known as "shaded" ADLs.[40] An individual may also qualify for waiver services by having a certain minimum level of nursing needs, and/or a certain level of cognitive or behavioral problems, *combined with* a certain minimum level of need for physical assistance with ADLs.[41]

The regulation governing the frequency with which an applicant for waiver services can request a reassessment is 7 AAC 130.211. That regulation provides in relevant part as follows:

> (a) The department will pay for and review, in any 365-day period, one screening of an applicant for home and community-based waiver services to determine whether there is a reasonable indication that the applicant might need services at a level of care provided in a hospital, nursing facility, or

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37 7 AAC 130.215.
38 7 AAC 130.215.
39 Exhibit E31.
40 Exhibit E31.
41 Exhibit E31.

> ICF/IID in 30 or fewer days unless the applicant receives home and community-based waiver services under this chapter . . . .
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> . . .
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> (c) Following a decision by the department that an applicant would not need services as specified in (a) of this section, the applicant may request, and the department will pay for and review, another screening if a material change in the applicant's condition occurred after a prior screening. In this subsection, "material change in the applicant's condition" means an alteration in the applicant's health, behavior, or functional capacity of sufficient significance that the department is likely to reach a different decision regarding the applicant's need for home and community-based waiver services.

C. Has Ms. D Proven a Material Change Since her Last Assessment?

As stated in Section I, above, the issue in this case is *not* whether Ms. D currently qualifies for waiver services. Rather, under 7 AAC 130.211(c), the issue in this case is whether, since the original assessment on April 15, 2015, there has been an alteration in Ms. D's health, behavior, or functional capacity of sufficient significance that the Department of Health and Social Services is likely to reach a different decision regarding Ms. D's need for waiver services. In order to decide this issue, it is necessary to consider any evidence indicating that Ms. D's nursing needs have increased, and/or that her functional abilities have decreased, since the April 15, 2015 assessment.

As discussed in Section I, above, on June 26, 2015, just over two months after the original assessment, Ms. D fell and was taken to a hospital emergency room.[42] She was found to have fractured her left hip[43] and was admitted to the hospital, where she remained from June 26, 2015 through July 21, 2015. She was found to have severe osteoarthritis of both hips, with complete loss of joint space, femoral head flattening, and significant subchondral cyst formation,[44] and surgery was performed on June 27, 2015 to repair the neck of her left femur.[45] Following her surgery, Ms. D remained in the hospital until August 5, 2015.

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[42] All factual findings in this paragraph are based on Exhibit 1 p. 2 and Ex. 3 pp. 67, 70, and 71 unless otherwise stated.

[43] Ex. 3 pp. 51 - 52.

[44] Ex. 3 p. 8.

[45] Ex. 3 p. 50.

On July 18, 2015 an MRI was taken of Ms. D's lumbar spine.[46] The MRI revealed focal kyphosis, moderate to severe central canal stenosis, posterior disc protrusion, disc desiccation, and a small annular fissure at T12-L1.

On January 25, 2016 Ms. D underwent a physical therapy assessment.[47] The assessment found Ms. D's mobility to be at least 80% impaired, and recommended that she undergo physical therapy three times per week for eight weeks. Based on the 80% level of impairment found by this physical therapy assessment, it would not be unlikely for a new CAT assessment to determine that Ms. D now requires extensive assistance with transfers, locomotion, and toilet use. Under the CAT, such a finding would result in Ms. D being found eligible for waiver services, even in the absence of any showing of a need for intermediate or skilled nursing services.[48] Accordingly, even without considering Ms. D's testimony at hearing,[49] the medical evidence, by itself, indicates that there has been a "material change" in Ms. D's condition since the prior (April 15, 2015) assessment.

In addition, at hearing, Mary Tanaka, R.N. (the assessor who performed Ms. D's original assessment) testified (in admirable candor) that she felt Ms. D would benefit from a new assessment. This testimony indicates that Ms. Tanaka believes there is at least a significant possibility that Ms. D might qualify for waiver services were she reassessed.

In summary, the preponderance of the evidence indicates that there has been a "material change" in Ms. D's condition, as defined by 7 AAC 130.211(c), in the months following Ms. D's original assessment on April 15, 2015. Accordingly, Ms. D is entitled to a new assessment of her eligibility for waiver services now, without waiting for the end of the normal one year reassessment period.

IV. Conclusion

While Ms. D may or may not be eligible to receive waiver services at present, she has proven, by a preponderance of the evidence, that her condition has materially changed since the assessment of April 15, 2015. Accordingly, Ms. D is entitled to a new assessment

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[46] All factual findings in this paragraph are based on Exhibit 3, pp. 48, 49, 62, and 66 unless otherwise stated.

[47] All factual findings in this paragraph are based on Exhibit 7, pp. 1 - 3 unless otherwise stated.

[48] *See* CAT scoring page at Exhibit E32.

[49] Ms. D testified at hearing that her Stickler syndrome is a progressive and aggressive auto-immune disease, and that her symptoms have worsened since the April 15, 2015 assessment. This testimony was not contradicted, and would be consistent with, and would explain, the physical therapist's finding of an 80% impairment in Ms. D's mobility.

(or early reassessment) pursuant to 7 AAC 130.211(c). The Division's determination, denying Ms. D a new assessment, is therefore reversed.

DATED this 9th day of February, 2016.

Signed
Jay 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 18th day of February, 2016.

By: *Signed*
Name: Jay D. Durych
Title: Administrative Law Judge, DOA/OAH

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