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

In the Matter of:	)	
	)	
K D	)	OAH No. 13-1305-MDS
	)	Agency No.
	)	

DECISION

I. Introduction

K D was receiving 34 hours per week of personal care assistance (PCA) services. The Division of Senior and Disabilities Services (Division) notified him on September 5, 2013 that his PCA services were being reduced to 14.75 hours per week. Mr. D requested a hearing.

Mr. D's hearing was held on December 3, 2013 and February 20, 2014. F D, Mr. D's wife and power-of-attorney, represented Mr. D with the assistance of G X. Shelly Boyer-Wood represented the Division.

The Division's reduction of Mr. D's benefits failed to take his care needs fully into account. The Division understated Mr. D's care needs with regard to transfers, locomotion in room, dressing, eating, and toileting. The Division, however, was required to eliminate any PCA assistance, regardless of need, for bed mobility and IADLs due to regulatory requirements. The Division's decision is therefore upheld in part and reversed in part as discussed more fully below.

II. The PCA Service Determination Process

The Medicaid program authorizes PCA services for the purpose of providing "*physical assistance* with activities of daily living (ADL), *physical assistance* with instrumental activities of daily living (IADL), and other services based on the *physical condition* of the recipient . . . ."[1] Accordingly, "[t]he department will not authorize personal care services for a recipient if the assessment shows that the recipient only needs assistance with supervision, cueing, and setup in order to independently perform an ADL or IADL."[2]

The Division uses the Consumer Assessment Tool or "CAT" to determine the level of physical assistance that an applicant or recipient requires in order to perform their ADLs and their

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[1] 7 AAC 125.010(a) [emphasis added].

[2] 7 AAC 125.020(e). This regulation defines "cueing" as "daily verbal or physical guidance provided to a recipient that serves as a signal to the recipient that the recipient needs to perform an activity;" "setup" as "arranging items for use or getting items ready for use so that the recipient can independently perform an ADL or IADL;" and "supervision" as "observing and giving direction, as needed, so that the recipient can independently perform an ADL or IADL." *Id.*

IADLs.[3] The ADLs measured by the CAT are bed mobility, transfers (non-mechanical), transfers (mechanical), locomotion (in room), locomotion (between levels), locomotion (to access apartment or living quarters), dressing, eating, toilet use, personal hygiene, personal hygiene-shampooing, and bathing.[4]

The CAT numerical coding system has two components. The first component is the *self-performance code.* These codes rate how capable a person is of performing a particular activity of daily living (ADL). The possible codes are **0** (the person is independent and requires no help or oversight); **1** (the person requires supervision); **2** (the person requires limited assistance[5]); **3** (the person requires extensive assistance[6]); **4** (the person is totally dependent[7]). There are also codes which are not used in calculating a service level: **5** (the person requires cueing); and **8** (the activity did not occur during the past seven days).[8]

The second component of the CAT scoring system is the *support code*. These codes rate the degree of assistance that a person requires for a particular ADL. The possible codes are **0** (no setup or physical help required); **1** (only setup help required); **2** (one person physical assist required); **3** (two or more person physical assist required). Again, there are additional codes which are not used to arrive at a service level: **5** (cueing required); and **8** (the activity did not occur during the past seven days). [9]

The CAT also codes certain activities known as "instrumental activities of daily living" (IADLs). These are light meal preparation, main meal preparation, light housekeeping, laundry (in-home), laundry (out-of-home), and shopping. [10]

The CAT codes IADLs slightly differently than it does ADLs. The *self-performance codes for IADLs* are **0** (independent either with or without assistive devices - no help provided); **1** (independent with difficulty; the person performed the task, but did so with difficulty or took a great amount of time to do it); **2** (assistance / done with help - the person was somewhat involved in the

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3 *See* 7 AAC 125.020(a) and (b).

4 Ex. E, pp. 6 – 11.

5 Pursuant to 7 AAC 125.020(a)(1), limited assistance with an ADL "means a recipient, who is highly involved in the activity, receives direct physical help from another individual in the form of guided maneuvering of limbs, including help with weight-bearing when needed."

6 Pursuant to 7 AAC 125.020(a)(2), extensive assistance with an ADL "means that the recipient is able to perform part of the activity, but periodically requires direct physical help from another individual for weight-bearing support or full performance of the activity."

7 Pursuant to 7 AAC 125.020(a)(3), dependent as to an ADL, or dependent as to an IADL, "means the recipient cannot perform any part of the activity, but must rely entirely upon another individual to perform the activity."

8 Ex. E, p. 18.

9 Ex. E, p. 18.

10 Ex. E, p. 26.

activity, but help in the form of supervision, reminders, or physical assistance was provided); and **3** (dependent / done by others - the person is not involved at all with the activity and the activity is fully performed by another person). There is also a code that is not used to arrive at a service level: **8** (the activity did not occur). [11]

The *support codes* for IADLs are also slightly different than the support codes for ADLs. The support codes for IADLs are **0** (no support provided); **1** (supervision / cueing provided); **2** (set-up help); **3** (physical assistance provided); and **4** (total dependence - the person was not involved at all when the activity was performed). Again, there is an additional code that is not used to arrive at a service level: **8** (the activity did not occur). [12]

The codes assigned to a particular ADL or IADL determine how much PCA service time a person receives for each occurrence of a particular activity. For instance, if a person is coded as requiring extensive assistance (code of 3) with bathing, he would receive 22.5 minutes of PCA service time each time he was bathed.[13] Even if the Division agrees that the amount of time provided by the formula is insufficient for a particular PCA recipient's needs, the regulations do not provide the Division with the discretion to change the amounts specified by the formula.

III. Facts

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

Mr. D is 65 years old. He is diabetic, has hypertension, Emphysema/COPD, is morbidly obese, has had a stroke with hemiplegia, and experiences dementia.[14] His hemiplegia, or hemiparesis more correctly, consists of left-sided weakness.[15] He uses a both a X and a wheelchair. The X is used on the upstairs portion of his home. He uses a stair glide to move from the upper part of the home to the lower part of the home, which contains his music room and the garage. He is a smoker and goes downstairs to smoke.

Mr. D was receiving 34 hours per week of PCA services in 2013. He was reassessed to determine his ongoing eligibility and benefit level on May 8, 2013. As part of his assessment, the Division's nurse assessor evaluated his overall physical functioning. She found that he was able to touch his hands over his head, touch his hands behind his back, that he had a strong grip in both

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11 Ex. E, p. 26.

12 Ex. E, p. 26.

13 *See* 7 AAC 125.024(a)(1) and the Division's *Personal Care Assistance Service Level Computation* chart contained at Ex. B, pp. 34 - 36.

14 Ex. P, p. 5.

15 See, *e.g.*, medical notes of December 10, 2012, stating that Mr. D has left-sided hemiparesis, left-sided weakness, and "left facial droop, left sided weakness." (Ex. P, pp. 2, 3, 5).

hands, was able to touch his feet, but that he could not place his hands on his chest and stand up.[16] Mr. D had those same physical functioning tests performed in 2011 and 2012. The 2011 results were that he was able to touch his hands over his head, was not able to touch his hands behind his back, that he had a weak grip in both hands, was not able to touch his feet, and he could not place his hands on his chest and stand up.[17] The 2012 results were that he was able to touch his hands over his head, was able to touch his hands behind his back, that he had a weak grip in both hands, was not able to touch his feet, and he could not place his hands on his chest and stand up.[18]

The end result of the 2013 assessment, as recorded in the Consumer Assessment Tool (CAT), resulted in an initial reduction of Mr. D's PCA services from 34 hours per week to 12.5 hours per week. That amount was subsequently increased to 14.75 hours per week.[19] The changes consisted of a complete elimination of the time previously provided to him for his Activities of Daily Living (ADLs) of body mobility, eating, and an elimination of the time previously provided him for his Instrumental Activities of Daily Living (IADLs) of light and main meal preparation, shopping, light housework, and laundry. In addition, the Division reduced the amount of assistance that Mr. D received for transfers and multi-level locomotion. B B, who has been Mr. D's PCA for between four to five years, was the primary witness on his behalf. There was evidence presented that Mr. D's condition has deteriorated substantially since September 5, 2013, the date of the Division's PCA reduction decision. Ms. B was instructed to confine her testimony to Mr. D's care needs as of the beginning of September 2013, and to not testify regarding any increase in his needs since that time frame.

The Division attempted to discredit Ms. B's testimony because she contacted his medical providers and informed them that his PCA hours were being substantially reduced. David Chadwick, who is employed by the Division, contacted some of the medical providers who wrote letters on Mr. D's behalf. He testified, for instance, that the PCA informed the urologist that Mr. D

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[16] Ex. E, p. 4.

[17] Ex. F, p. 4.

[18] Ex. S, p. 4. The 2012 CAT was not provided as part of the Division's exhibits. It was supplied by Mr. D on December 16, 2013. It is marked as Exhibit S.

[19] Mr. D's PCA hours were originally decreased to 12.5 hours per month. (Ex. D, pp. 1, 6). However, the Division subsequently reviewed his PCA hours, which were then set to 14.75 hours per month. (Shelly Boyer-Wood December 3, 2013 statement; Ex. K). Exhibits D, p. 6, and K must be read in concert to determine the amount of the reductions. Exhibit D, p. 6, in the columns entitled "Prior Assessment Self Perform/Support Score" and "Prior Assessed Weekly Frequency", contains the support scores and frequency for the PCA services he was receiving prior to the reduction. Exhibit K, in the columns entitled "Current Assessment Self Perform/Support Score", "Current Assessed Weekly Frequency" and "Total Weekly Minutes Authorized", contains the support scores, frequency, and time allotted for the PCA services he was to receive after the reduction.

was going to lose his PCA hours completely.[20] However, Dr. Lund's December 9, 2013 letter stated that he did not speak to the PCA but was provided a message from his front desk that Mr. D was going to lose his PCA hours.[21] Dr. Lund's letter that was provided in response to the message is quite general and merely states that "[w]ithout PCA assistance, Mr. D may not be able to keep himself clean and may develop skin infections . . ."[22] It is therefore unknown what Ms. B's communication with Dr. Lund's front desk was. A review of the other physician's letters does not support the Division's contention that Ms. B provided incorrect information to Mr. D's medical providers. For instance, Dr. Hornbein's letter specifically refers to the reduction of hours from 34.25 to 12.5.[23] Further, the letters sent by Mr. Chadwick to the medical providers about Mr. D's condition, which request clarification about the letters they sent regarding Mr. D's PCA service reduction, could potentially confuse or misdirect a casual reader from the relevant issue of PCA service reduction. For instance, even though the letter sent by Mr. Chadwick to Dr. Lund specifically refers to the reduction of PCA services from 34.25 hours to 12.25 hours, it recites that Mr. D's total services (chore, respite, adult day care, and PCA) were reduced from 72.25 hours to 52.25 hours per week, when the relevant issue was only the reduction of PCA services. Further, the letter states that Mr. D receives 10 hours per week of chores services after the reduction, when his service plan only allows 5 hours.[24] The potential for the Division's inquiry letters to influence Mr. D's medical providers is demonstrated by Dr. Scully's December 17, 2013 response:

> This letter is in reference to one of my cardiac patients at Alaska Heart Institute, Mr. K D. This letter is to clarify my actions regarding a letter drafted October 23, 2013 requesting more hours for his PCA/caregiver. I wrote this letter without knowledge of how many hours Mr. D actually receives each week. I wrote this letter at the request of B, who identified herself as the patient's caregiver. I was informed by the caregiver that the patient's PCA hours had been cut, and I was requested to write a letter to ask for reinstatement of PCA hours. I wrote this letter on October 23rd.

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20 David Chadwick testimony (February 20, 2014).

21 Ex. I, p. 2.

22 Ex. L, p. 3.

23 Ex. L, p. 1 (Dr. Hornbein letter regarding reduction of hours from "about 34 hours per week to 12.5 hours per week); Ex. L, p. 2 (Dr. Scully letter stating "it has come to my attention K does not have access to his PCA for as many hours as he used to."); Ex. L, p. 3 (Dr. Lund letter stating "I have been asked to write a letter of behalf of Mr. D regarding his need for PCA assistance."); Ex. L, p. 4 (Dr. Halverson letter stating "I am recommend[ing] that his PCA hours of 34.25 hours be reinstated to assist him in his activity of daily living and to insure a measure of safety from future falls."); Ex. L, p. 5 (No Name Pain Clinic letter stating "it is medically necessary that his PCA hours be increased due to increased pain and overall decreased function in daily activities.").

24 December 3, 2013 letter to Dr. Lund (Ex. J); September 11, 2013 Service Plan Approval and Service Plan (Ex. O, pp. 1, 11).

> It has since come to my attention that the patient was actually receiving quite a few hours of assistance per week. I believe he was actually receiving greater than 70 hours per week. In retrospect, I would not have written this letter had I had knowledge of his other available services.[25]

Consequently, the Division did not succeed in its attempt to discredit Ms. B's testimony. Ms. B, who is quite knowledgeable about Mr. D's care needs given her length of time caring for Mr. D, provided consistent details in her testimony.[26] She was a thoughtful and credible witness.

Mr. D's specific areas of disagreement are addressed below:

A. Bed Mobility

Mr. D was previously provided with extensive physical assistance (self-performance code 3, support code 2) with bed mobility twice daily, seven days per week.[27] His bed mobility assistance was removed because the Division found that he was ambulatory using a X, which made him ineligible for bed mobility assistance.[28]

Mr. D's PCA testified that he required weight-bearing assistance with repositioning himself in bed: his left side is a "dead weight"; his legs have to be lifted up; he is not capable of sitting up from a lying position; and he is not capable of turning himself from side to side.[29]

B. Transfers

Mr. D was previously provided with extensive physical assistance (self-performance code 3, support code 2) with transfers four times daily, seven days per week.[30] The Division reduced his PCA assistance to limited physical assistance (self-performance code 2, support code 2) four times daily, seven days per week.[31]

The 2013 assessor's finding that Mr. D required limited physical assistance was based upon her observation that Mr. D's PCA provided him with a one-handed assist to get up from his liftchair and to and from his stairglide.[32] Mr. D's PCA, however, testified that he required weight bearing assistance, *i.e.*, extensive assistance, to transfer to and from his bed and liftchair. She also testified that he needed weight-bearing assistance to transfer to and from his stairglide and wheelchair. Her

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25 Ex. R, p. 2.

26 F D, Mr. D's wife, and E D, who is Mr. D's service coordinator with the PCA agency, both testified on February 20, 2014. Their testimony was consistent with that of Ms. B.

27 Ex. D, p. 6; Ex. K.

28 Ex. E, p. 5; Ex. K.

29 B B testimony (February 20, 2014).

30 Ex. D, p. 6.

31 Ex. K.

32 Marianne Sullivan testimony (December 3, 2013); Ex. E, p.6. Marianne Sullivan was the Division's assessor. She testified on both December 3, 2013 and February 20, 2014. Her testimony on February 20, 2014 was very limited due to her limited availability and exceedingly poor telephone connections (Ms. Sullivan was traveling in rural Alaska).

testimony is consistent with both the 2011 and 2012 CATs, which found that Mr. D required extensive assistance.[33] The Division has the burden of proof on this point because it is seeking to reduce the level of assistance from extensive to limited. Given the PCA's long familiarity with Mr. D's care needs, having been his PCA for at least four years, Mr. D's age (65), and health conditions, including morbid obesity (5'11", 264 lbs.), and having left-sided weakness, it is unlikely that his need for transfer assistance has improved.[34] The Division has not met its burden of proof on this point, and it is more likely true than not true that Mr. D continues to require extensive physical assistance with transfers.

Mr. D requested an increase in the frequency of transfers from four times daily to six times daily. His PCA's testimony regarding his transfers shows that he transfers frequently. He is a smoker who has to go downstairs in his home to smoke and use his music room. He has to transfer to and from his stairglide to access the downstairs. He has a wheelchair downstairs, which he uses, which he has to be transferred in and out of. And he has to get in and out of bed. While Mr. D does go to an adult daycare program several days per week, he requires, per the PCA's testimony, transfers of at least six times per day even on the days that he goes to daycare.[35]

Because this is a request for an increase in transfers from four to six times daily, seven days per week, Mr. D has the burden of proof on this point. He has met his burden and demonstrated that it is more likely true than not true that he requires transfers six times per day, seven days per week.

C. Locomotion In Room

Mr. D was previously provided with limited assistance (self-performance code 2, support code 2) with locomotion six times daily, seven days per week.[36] The Division kept the level of assistance at limited physical assistance (self-performance code 2, support code 2) but reduced the frequency to four times daily, seven days per week.[37]

Mr. D's PCA's testimony was that Mr. D does not require weight-bearing assistance, but that she has to walk next to him, hold on to him, and remind him to pick up his left leg. When asked regarding the frequency of assistance, the PCA provided several estimates. However, the minimum amount she provided was six times per day, which is consistent with the prior amount

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33 B B testimony (February 20, 2014).

34 Mr. D's condition has, per the testimony of B B, F D, and E D, deteriorated since September 2013. The witnesses, however, were cautioned to only describe Mr. D's care needs up to the date of the Division's decision to reduce services, which was September 5, 2013.

35 B B testimony (February 20, 2014).

36 Ex. D, p. 6.

37 Ex. K.

assessed and the discussion above regarding transfers.[38] In contrast, when the Division's assessor was asked the reasons for reducing the locomotion frequency from six to four, her explanation was confusing, and referred to the multiple floor nature of the house and to locomotions downstairs, to Mr. D's locomotion to adult daycare and to his medical appointments.[39] Given the confusing nature of the assessor's answer, which appeared to be based on the total frequency of locomotion for all activities, rather than the specific category of locomotion in room, and the consistency of the PCA's testimony with the prior amount of transfer assistance allowed, the Division did not meet its burden of proof on this decrease. Accordingly, it is more likely true than not true that Mr. D continues to require limited assistance (self-performance code 2, support code 2) with locomotion six times daily, seven days per week.

D. Dressing

Mr. D was previously provided with extensive physical assistance (self-performance code 3, support code 2) with dressing twice daily, seven days per week.[40] The Division reduced his PCA assistance to limited physical assistance (self-performance code 2, support code 2) twice daily, seven days per week.[41]

The assessor's reduction in the level of assistance from extensive to limited was based upon her observation of Mr. D putting his jacket on.[42] The PCA's testimony was that Mr. D could assist and use his right arm, but he was limited in the use of his left arm. She also testified that Mr. D was able to lift his right leg, but was not able to lift his left leg to assist in dressing.[43] The PCA's testimony describes weight-bearing assistance; it is consistent with Mr. D's diagnosis of left-sided weakness; it places Mr. D in the extensive assistance category. It is also consistent with the 2011 and 2012 assessments, both of which found Mr. D to require extensive assistance with dressing.[44]

The Division had the burden of proof on this point because it was seeking to reduce the level of assistance. It did not meet its burden. Given the consistency of the evidence, excepting the 2013 assessor's findings, it is more likely true than not true that Mr. D continues to require extensive physical assistance with dressing twice daily, seven days per week.

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38 B B testimony (February 20, 2014).
39 Marianne Sullivan testimony (December 3, 2013 at 31:14 – 38:40).
40 Ex. D, p. 6.
41 Ex. K.
42 Marianne Sullivan testimony (December 3, 2013); Ex. E, p. 8.
43 B B testimony (February 20, 2014).
44 Exs. F, p. 8; S, p. 9.

E. Eating

Mr. D was previously provided supervision assistance with eating due to choking hazards.[45] The new assessment found that he did not require eating supervision.[46] The assessor did not allow time for eating supervision based on her observation that Mr. D was able to swallow medication easily and her watching him eating a banana.[47] Although the assessor acknowledged that Mr. D has a dysphagia diagnosis, she said that would not provide him with eating assistance.

Mr. D has a GERD diagnosis with medically noted difficulty in swallowing.[48] His PCA testified that he had trouble with choking while eating.[49] The Division has the burden of proof because it is seeking to eliminate Mr. D's PCA services for eating supervision. Based upon the medical evidence and the testimony of Mr. D's PCA, the Division did not meet its burden. It is more likely than not true that Mr. D continues to require PCA assistance for eating supervision due to choking hazards.

F. Toileting

Mr. D was previously provided with extensive physical assistance (self-performance code 3, support code 2) with toileting seven times daily, seven days per week.[50] The Division reduced his PCA assistance to limited physical assistance (self-performance code 2, support code 2) four times daily, seven days per week.[51]

The Division has the burden of proof on this issue because it is seeking to reduce the level of assistance and the frequency of assistance. As discussed above with regard to transfers, Mr. D requires extensive physical assistance with transfers. He would also therefore need extensive physical assistance with transfers on and off the toilet. His PCA testified that he required physical assistance cleansing and dressing himself after toileting, which further supports his need for extensive assistance.[52]

The frequency of assistance is more problematical. Mr. D is bladder incontinent and wears incontinence products. Changing those products is included within the definition of toileting. The assessor explained that she reduced the frequency of assistance from seven times daily to four times

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45 Ex. D, p. 6.
46 Ex. K.
47 Ex. E, p. 9; Marianne Sullivan testimony (December 3, 2013).
48 See medical notes of December 10, 2012. (Ex. P, pp. 2, 4).
49 B B testimony (February 20, 2014).
50 Ex. D, p. 6.
51 Ex. K.
52 B B testimony (February 20, 2014).

daily based on the PCA's statement that Mr. D only required toileting assistance four times daily. She also stated that because he attends adult daycare several times per week, he would not need PCA assistance during that time.[53] However, urologist notes of May 13, 2013, shortly after Mr. D's May 8, 2013 assessment, state that Mr. D goes through six incontinence pads a day, and has "severe urge incontinence and urinary frequency."[54] Mr. D, in addition, to being incontinent, also uses a bedside urinal which has to be emptied by his PCA, and still requires the bathroom for bowel movements.[55] His PCA estimated that he has incontinence episodes eight times per day plus using the bathroom for bowel movements two to three times per day. This would come to a minimum of 10 times per day. Her estimate regarding the days Mr. D goes to daycare were that she changes him twice before daycare (11 a.m. pickup) and then he requires changes at least once afterward, and that he still uses the bathroom at least once on daycare days.[56] This comes to a minimum of four times per day on daycare days. Mr. D's plan of care provides for adult daycare of 10 hours per week for the period from July 1, 2013 through May 7, 2014.[57] The evidence showed that Mr. D went to adult daycare three to four days per week as of September 2013.[58] Assuming that he went to adult daycare four days per week, he would need toileting assistance 10 times per day on non-daycare days (3 x 10) and four times per day on daycare days (4 x 4). This comes to a total of 46 times per week, which does not include any time for emptying the bedside urinal. Assuming the bedside urinal is emptied once daily, this would come to 53 toileting assists per week.

The Division had the burden of proof to demonstrate that Mr. D's toileting frequency should be reduced to four times per day, seven days per week. However, it failed to do so. The evidence, even making assumptions such as Mr. D going to daycare four days per week, shows that Mr. D continues to require toileting assistance at least seven times per day, seven days per week.[59]

G. Non-Sterile Dressings

Mr. D was not provided with any PCA assistance for non-sterile dressing changes in his previous service plan.[60] At hearing, he requested this service. This is an increase in services upon

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53 Ex. E, p. 9; Marianne Sullivan testimony (December 3, 2013).
54 Ex. I, p. 4.
55 Ex. E, p. 9; Ex.
56 B B testimony (February 20, 2014).
57 Ex.
58 B B testimony (February 20, 2014).
59 While 53 times per week comes to an average of 7.57 times per day, seven days per week, the average daily frequency, when rounded down, is seven times per day.
60 Ex. D, p. 6.

which he bears the burden of proof.[61] The May 2013 assessment shows that Mr. D had a wound for which he went to the wound care center three days per week.[62] The PCA testified that she also changed the dressing daily, even on days when he went to the wound care center. Not to discount her testimony, this appears to be a duplication of medical care, and consequently, Mr. D has not established that he requires daily bandage changes from his PCA.

H. Instrumental Activities of Daily Living

Mr. D was receiving IADLs through the PCA program.[63] However, those services were removed in September 2013.[64] At roughly the same time his IADL services were removed, he was approved to receive five hours per week of chore services through the Medicaid Waiver program.[65]

IV. Discussion

The Division reduced Mr. D's PCA services from 34 hours per week to 14.75 per week hours per week in PCA services as a result of his May 8, 2013 assessment. While there was evidence showing that Mr. D's condition has deteriorated substantially since September 2013, this decision is required to be based upon Mr. D's needs as of the date of the Division's decision, September 5, 2013, that his benefits were reduced.[66]

This case has mixed burdens of proof because the Division is seeking to reduce some benefits while Mr. D is seeking to increase some benefits.[67] The standard of proof on factual issues is the preponderance of evidence, *i.e.,* whether something is more likely true or not true.

A. ADLs

Mr. D challenged the amount of PCA services he was provided with regard to bed mobility, transfers, locomotion in room, dressing, eating, and toileting. As discussed above, the facts of this case show the following:

- Mr. D's bed mobility assistance was removed, not because he is fully able to reposition himself in bed,[68] but because he is able to ambulate using his X. As the factual findings on locomotion provided above state, Mr. D is able to ambulate but

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61 7 AAC 49.135.

62 Ex. E, p. 6.

63 Ex. D, p. 6.

64 Ex. D, pp. 3.

65 Ex. O, pp. 1, 11.

66 *See* 7 AAC 49.170; *In re T.C.*, OAH No. 13-0204-MDS (Commissioner of Health & Soc. Serv. 2013) (http://aws.state.ak.us/officeofadminhearings/Documents/MDS/HCW/MDS130204.pdf).

67 7 AAC 49.135.

68 This decision makes no factual finding regarding Mr. D's self-performance abilities with regard to bed mobility.

requires limited assistance to do so. The applicable regulation, 7 AAC 125.030(b)(1)(A), only allows PCA services for "positioning or turning in a bed or chair, if the recipient is nonambulatory." Because Mr. D is ambulatory, he cannot receive body mobility assistance.

- Mr. D continues to require extensive assistance with transfers. He has met his burden and demonstrated that it is more likely true than not true that the number of times he is provided transfer assistance should be increased to six times per day, seven days per week.
- Mr. D continues to require limited assistance with locomotion six times per day, seven days per week.
- Mr. D continues to require extensive assistance with dressing twice daily, seven days per week.
- Mr. D continues to require supervision assistance with eating due to choking hazards. The applicable regulation, 7 AAC 125.030(b)(5)(C), does not require that a recipient have a prescription for supervised eating.[69]
- Mr. D continues to require extensive one-person physical assistance (self-performance code 3, assistance code 2) with toileting seven times per day, seven days per week.
- Mr. D does not require PCA assistance for dressing/bandage changes.

B. IADLs

Mr. D's IADLs were removed because he was instead receiving chore services through the Medicaid Home and Community-based Waiver program. Regulation 7 AAC 125.040(d) specifically prohibits a person from receiving IADL PCA services if he or she receives chore services through the Waiver program. As a purely legal matter, the Division was required to remove Mr. D's IADLs once he was approved for chore services through the Waiver program.

[69] Marianne Sullivan's December 3, 2013 testimony suggested that in order to be eligible for supervised eating, a recipient must require assistance such as having to have liquids thickened, and also must have a prescription. (47:06 – 49:35). Neither of these requirements are contained in regulation 7 AAC 125.030(b)(5)(C) or in the Personal Care Assistance Service Level Computation (Ex. B, p. 34). The Division argued, referring to the Personal Care Assistance Service Level Computation (Ex. B, p. 34), that it could not approve eating supervision assistance because §K(3)(a) of the CAT, indicating there were chewing or swallowing problems, was not checked. However, the hearing process allows a recipient to dispute the CAT's findings. And as found in the earlier discussion, Mr. D established that he has a medically documented issue with swallowing, and his PCA testified that he chokes while eating. §K(3)(a) should have been checked indicating there were chewing or swallowing issues.

C. Escort

Mr. D was provided with 15.38 minutes per week for escort services as a result of his 2013 assessment.[70] At the close of the hearing, the Division argued that his escort services should be eliminated in their entirety. The Division's argument was based upon a theory that because Mr. D has a power of attorney, the power of attorney is required to attend Mr. D's medical appointments and that his PCA may not. This argument is not persuasive for two separate reasons. First, as a purely procedural matter, the Division may not assert a new reduction claim at hearing. The Division's actions, its reasoning, and the regulatory/statutory support for them must be contained in its original notice.[71] Second, there is a recent decision which specifically holds, reversing a prior decision, that a PCA may provide escort services when there is an appointed power-of-attorney.[72] Accordingly, Mr. D's escort services remain intact.

V. Conclusion

Mr. D has substantial care needs. The Division's reduction of his benefits failed to take those care needs fully into account. The Division understated Mr. D's care needs with regard to transfers, locomotion in room, dressing, eating, and toileting. The Division, however, was required to eliminate any PCA assistance, regardless of need, for bed mobility and IADLs due to regulatory requirements. The Division is to recalculate Mr. D's needs for PCA assistance consistent with this decision.

DATED this 25th day of March, 2014.

Signed
Lawrence A. Pederson
Administrative Law Judge

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70 Ex. D, p. 6; Ex. K.

71 Federal Medicaid regulation 42 C.F.R. § 431.210 requires that when the Division provides notice of an agency action regarding benefits, that notice must inform the recipient of the proposed action, the reasons for the action, and what regulations support that action. The Alaska Fair Hearing regulations, 7 AAC 49.070, also contain similar language: "the department will state in the written notice the reasons for the proposed action." Those notice requirements are discussed in *Allen v. State, Dept. of Health and Social Services, Division of Public Assistance*, 203 P.3d 1155, 1167 - 1168 (Alaska 2009) and *Baker v. State, Dept. of Health and Social Services*, 191 P.3d 1005, 1009 (Alaska 2008). *Also see* OAH Case No. 13-1517-MDS, p. 10 (Commissioner of Health & Social Services, adopted March 14, 2014 – not yet published).

72 OAH Case No. 13-1782-MDS, p. 5 ((Commissioner of Health & Social Services, adopted February 19, 2014 – not yet published).

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 14th day of April, 2014.

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.]