

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

In the Matter of)
)
D H) OAH No. 18-0050-MDS
) Agency No.
_____)

DECISION

I. Introduction

D H receives services under the Intellectual and Developmental Disabilities (“IDD”) Medicaid Home and Community Based Waiver program due to a severe traumatic brain injury. Among the Waiver services D receives is day habilitation. In October 2017, the Division of Senior and Disabilities Services (“Division”) began implementing new IDD Waiver program regulations, including a new regulation that placed new limits on the number of day habilitation hours a recipient may receive. That regulation limited a recipient’s day habilitation hours to no more than twelve hours per week, unless additional hours are necessary to protect the recipient’s health and safety and to prevent institutionalization.

For her 2017-2018 plan of care, and based on the change to its regulations, the Division approved D for only twelve hours of weekly day habilitation, denying the remaining eight hours per week that were requested. After D’s guardian appealed the Division’s determination, the evidence at hearing established that more than twelve hours of day habilitation are, more likely than not, necessary to protect D’s health and safety, but did not support a finding that the additional hours (despite unquestionably beneficial) were *also* necessary to prevent institutionalization.

In the time between the hearing and the issuance of this decision, however, questions arose about whether the new regulation was effective at the time D’s plan of care was approved. Because the change to the IDD waiver program had not been approved by the federal Center for Medicaid Services (CMS) at the time of D’s plan of care renewal, and in fact did not become effective until March 20, 2018, the regulation cannot be applied to the plan of care submitted in November 2017. Accordingly, because the State IDD Waiver Plan had not yet been amended at the time D’s plan of care was submitted and reviewed, the Division’s decision to deny the additional hours of day habilitation is reversed.

II. Facts

A. Background

D H is a 31-year-old woman who lives in City A with her parents, who are her legal guardians. D suffered a traumatic brain injury in a tragic vehicular accident in which D was initially left in a vegetative state.¹ She has made significant gains since that time, but will continue to experience persistent deficits throughout adulthood.²

As a result of her traumatic brain injury, D continues to experience difficulty in independent living skills, social skills, and memory.³ As described by her neuropsychologist, “[n]eurological testing has consistently revealed impaired memory, impaired problem solving, and deficient language skills.”⁴ Cognitively and in terms of decision-making abilities, D functions in the range of a seven- to ten-year-old.⁵

D’s mother is her primary caregiver.⁶ D requires supervision and support to participate in community activities.⁷ While she enjoys such activities, she cannot be “dropped off” unattended and requires someone with her for supervision.⁸ Her mother reports that she has great difficulties with short term memory, and has zero “awareness of safety” – a combination that her mother fears “makes her vulnerable to predators.”⁹

B. D’s plan of care

D receives waiver services through the IDD program. Her services include supported living, individual day habilitation, agency-based respite, and agency-based daily respite.¹⁰ Both the supported living and day habilitation services are classified as “habilitative services.” Broadly speaking, “habilitative services” are those that “support the person to acquire, build, or retain” skills in areas including mobility, motor skills, self-care, communication, social skills, and other life skills.¹¹ “Habilitative services support self-help, socialization and adaptive skills aimed at raising the level of

¹ Ex. E, p. 12.

² Ex. E, p. 12.

³ Ex. E, pp. 7-8; H 2/15/18 submission, p. 2.

⁴ H 2/15/18 submission, p. 3 (X 2/1/18 letter).

⁵ T H testimony.

⁶ Ex. E, p. 7.

⁷ H 2/15/18 submission, p. 2.

⁸ H 2/15/18 submission, p. 2.

⁹ H 2/15/18 submission, p. 2.

¹⁰ Ex. D, p. 1.

¹¹ See Ex. E, p. 15.

physical, mental, and social functioning of an individual.”¹² D’s day habilitation services are the subject of the current dispute.

1. *Prior year’s plan of care*

D’s 2016-2017 plan of care described her as unable to live independently, because she “continues to lack necessary safety, decision-making, and problem-solving skills.”¹³ The plan of care reported that D had had two seizures the prior year, and was displaying increased memory problems.¹⁴ The plan of care described several periods during the prior waiver year when D had been without staff, apparently due to issues with the direct service provider agency, and expressed concerns that “the inconsistency causes many issues with D’s routine and growth to independence.”¹⁵ The plan of care included supported living services, day habilitation services, and agency-based respite.¹⁶ Her supported living goals involved using a “brain book” system to help organize her daily tasks, activities, and responsibilities.¹⁷ Her day habilitation goals involved participation in community activities that promote fine motor skills and therapeutic functioning.¹⁸

2. *Changes to the day habilitation regulation*

In August 2017, the Department amended certain Medicaid regulations, including 7 AAC 130.260(c), the regulation governing day habilitation hours. The Division began implementing these changes as of October 1, 2017.¹⁹ The revised regulation reads as follows:

The department will not pay for more than 624 hours per year of any type of day habilitation services from all providers combined, unless the department approves a limited number of additional day habilitation hours that were

- (1) requested in a recipient's plan of care; and
- (2) justified as necessary to
 - (A) protect the recipient's health and safety; and
 - (B) prevent institutionalization.²⁰

Care coordinators were notified of this change via email on September 11, 2017.²¹ The notice reflected that plans of care received after October 1, 2017 would be “reviewed in light of the new limit on

¹² Ex. E, p. 15.

¹³ Ex. F, p. 8.

¹⁴ Ex. F, p. 5.

¹⁵ Ex. F, pp. 5, 8.

¹⁶ Ex. F.

¹⁷ Ex. F, pp. 8-9.

¹⁸ Ex. F, p. 9.

¹⁹ The legality of these changes is currently being litigated in Juneau Superior Court and in Federal District Court.

²⁰ 7 AAC 130.260(c).

day habilitation services.” Providers were advised that “[r]equests for service amounts exceeding the yearly cap will be considered exceptions to the rule and should only be requested in extreme circumstances.” The email explained that the Division would review such requests “to determine whether a limited amount of additional day habilitation hours are necessary to protect a recipient’s health and safety and to prevent institutionalization,” and that such reviews would be undertaken “in the context of individual’s (sic) entire service plan and person centered goals.”

Although this regulation substantively changed the IDD Waiver program, the Department had not sought prior approval for this change from the federal Center for Medicaid Services (CMS). The Department did not submit a request to amend the state IDD Waiver plan until January 2018. CMS approved the amendment, which included this new imposition of new limits on day habilitation services, effective March 20, 2018.

3. 2017-2018 plan of care

On November 30, 2017, D’s team submitted a plan of care for the December 2017 – December 2018 plan year.²² The plan of care describes D as having had a stable year, with no health emergencies or other critical events, but also no improvements.²³ In describing D’s functional abilities and needs, the plan of care describes D as “unable to access her community independently. She requires full time supervision, as she lacks necessary safety, decision-making, and problem-solving skills to be left alone.”²⁴ Because of D’s skill deficits, the plan of care indicates that “consistent supervision and support” are “necessary to maintain her safety,” “to maintain her current adaptive skills,” and to “allow her to continue living in the least restrictive environment of her home and community.”²⁵

As with the previous year, the plan of care’s day habilitation goals includes community activity goals focused on improving D’s communication and fine motor skills, as well as a separate goal to “complete her assigned therapies [vision therapy and physical therapy] five days a week to maintain or improve her current level of function.”²⁶ Elsewhere in the plan of care, D’s PT plan – “developed through the Providence Outpatient Therapy PT” – is described as attending the gym 5 days a week, yoga

²¹ Ex. 1, p. 10.

²² Ex. E.

²³ Ex. E, p. 4.

²⁴ Ex. E, p. 9.

²⁵ Ex. E, p. 8.

²⁶ Ex. E, p. 8.

three 3 a week, and swimming 3 days a week, working with her direct service (day habilitation) provider on a variety of specific routines and hand therapies provided by her occupational therapist.²⁷

The plan of care expressly noted that the team was seeking eight additional hours over the “standard 12 hours a week” set out in the new regulations.²⁸ They described concerns that less time for exercising will cause atrophy, weakness, and emotional issues.²⁹ They also noted that her neuropsychologist, Dr. X, had expressed that “continuing services and supports at their current level will be necessary for D to maintain” the “significant adaptive gains” she has made since her injury.³⁰

D’s team accompanied her plan of care with an October 2, 2017 letter from her internist, K Y, D.O. Dr. Y, who has treated D for more than a decade, described her as experiencing “irreversible brain damage and related learning disorder and decreased cognitive function.” He stated his view that participation “in community exercise programs” has been “very helpful” both with her physical health and with “keeping her cognitive and socially engaged and stimulated.” He expressed the opinion that, “it is in D’s best interest to continue these community programs, and any decrease in her care plan would cause a significant decline in her physical and mental abilities.”³¹

D’s team also submitted an October 24, 2017 letter from her chiropractor, L M, D.C. Dr. M, who has treated D since 2006, shared his observations that “when she doesn’t maintain her strength and activity level, her health deteriorates as does her tolerance to physical activity.” Accordingly, in Dr. M’s view, “if she does not continue at the current rate, her disability will increase and in the medium to long-term, her needs and expenses will increase greatly.”³²

C. Division’s review and partial denial

D’s 2017-2018 plan of care was reviewed by Health Program Manager I Elias Haroun.³³ The Division, through Mr. Haroun, approved the requests for 20 hours per week of supported living; 10 hours per week of agency-based respite; and 14 days per year of agency based daily respite. Of the

²⁷ Ex. E, pp. 10-11 (noting “it is crucial that D work on these goals on a daily/weekly basis, as atrophy sets in immediately when there is a lapse. Staff should help her keep track of repetitions when working out as it is easy for her to lose count.”)

²⁸ Ex. E, p. 19.

²⁹ Ex. E, p. 19.

³⁰ Ex. E, p. 19.

³¹ Ex. E, p. 36.

³² Ex. E, p. 35.

³³ The Health Program Manager position requires certification as a QIDP – a Qualified Intellectual Disabilities Professional. In addition to meeting this requirement, Mr. Haroun has an undergraduate degree in social work and more than ten years working as a direct support professional with individuals with intellectual disabilities, including TBIs. He previously worked as a mental health associate, and as regional supervisor of a statewide program for individuals with intellectual disabilities, including brain injuries. Haroun testimony.

twenty hours per week of day habilitation requested, the Division granted the request for 12 hours, and denied the remaining 8 hours.³⁴

Mr. Haroun's December 12, 2017 letter cited the October 1, 2017 regulation changes as limiting day habilitation to 12 hours per week unless any additional hours requested are "justified as necessary to protect the recipient's health and safety and to prevent institutionalization."³⁵ Mr. Haroun concluded that the plan of care, and the supplemental letters provided from two of D's medical providers, did not meet this standard.³⁶

Mr. Haroun noted that the plan of care described D as healthy and essentially stable, and as using day habilitation to continue working on "maintaining her adoptive gains, independence, and her physical and emotional state."³⁷ While acknowledging that day habilitation activities are beneficial to D, Mr. Haroun found that the plan of care fell short of demonstrating why hours beyond the new presumptive limit of 12 per week "are necessary to protect D's health and safety and prevent institutionalization." He also noted that the plan of care did not address "what other alternative supports D's team explored," and concluded that her approved level of service, her available "natural supports," and other (unspecified) community activities were "of sufficient amount, scope, and duration to meet her needs and achieve the intent of the POC."³⁸

D. Appeal

D's mother, T H, timely appealed the partial denial. Mrs. H submitted documents to be considered as part of the appeal. A letter from D's neuropsychologist, Dr. S X, expressed that having 20 hours per week of day habilitation "has allowed [D] to maintain her physical and mental health, resulting in no emergency room visits or hospitalizations."³⁹ Reducing these hours, he opined, "will result in decline in her overall health and likely lead to the need for interventions she has been able to avoid over the years."⁴⁰

A January 4, 2018 letter from D's longtime physician T L urged that D has "worked hard and diligently" in her various prescribed therapies, but benefited greatly from the waiver services she receives, including the day habilitation. Dr. L, who has been D's rehabilitation provider since her initial injury and hospitalization 19 years ago, opined:

³⁴ Ex. D, p. 1.
³⁵ Ex. D, p. 2.
³⁶ Ex. D, p. 2.
³⁷ Ex. D, p. 2.
³⁸ Ex. D, p. 2.
³⁹ Ex. 2, p. 3.
⁴⁰ Ex. 2, p. 3.

She has reached functional ability that allows her with 24-hour supervision and one-on-one structured program to be part of the community. To maintain her skills that she has worked so hard to achieve and to maintain her present functional level, I believe she would benefit from the ongoing direct service provider individual care habilitation 20 hours per week.⁴¹

Lastly, a letter from Mrs. H stated that D's day habilitation assists her with socializing in the community, working on a variety of cognitive and memory skills, and maintaining physical health. Mrs. H described D's severe TBI, and her associated lack of adaptive and safety skills. Mrs. H urged that day habilitation services were essential to D's ongoing well-being, and that reducing her services was "not a person-centered decision," and would lead to a decline in D's progress and abilities.⁴²

The hearing on D's appeal was held on February 16, 2018, at the Office of Administrative Hearings. D was represented by Mrs. H, who indicated that D's care coordinator had, unfortunately, declined to participate in the hearing. The Division was represented by Fair Hearing Representative Victoria Cobo. In addition to Mrs. H's testimony, testimony was also taken from Mr. Haroun. All exhibits from both parties were admitted without objection.

In the Division's case presentation, Ms. Cobo described the decision-making on D's plan of care as having been limited by the new regulation's restrictiveness – specifically, the requirements as to both health and safety needs *and* prevention of institutionalization.

We do work within the regulations. Those in this case – the new regulations are very specific to consider what the Plan of Care is requesting, but also it has a limit, and the only way that the Division is able to authorize over that limit would be [for] health and safety needs *and* to prevent institutionalization.⁴³

Likewise, in his testimony, Mr. Haroun described his own knowledge and experience working with individuals with TBI, and explained that, while he was aware of and considered the effects of D's TBI, he felt "bound" by the new regulation's restrictions.⁴⁴

Due to regrettable circumstances beyond the scope of this decision, a decision on D's appeal was not promptly issued by the assigned hearing judge. On May 16, 2018, the case was reassigned from the original hearing judge to the undersigned, who carefully listened to the hearing recording, reviewed the

⁴¹ Ex. 1, p. 1.

⁴² Ex. 2, p. 1.

⁴³ Division's case presentation.

⁴⁴ Haroun testimony.

parties' exhibits, and invited post-hearing briefing on a potentially dispositive procedural question not previously addressed.⁴⁵ This decision follows.

III. Discussion

A. *Under the amended day habilitation regulation, D did not meet her burden of proof.*

Typically, if the Division is proposing a reduction in the level of services, it bears the burden of proving the reduction is appropriate.⁴⁶ An exception exists, however, if the reduction is solely due to a change in regulations.⁴⁷ Because the reduction here was solely due to the change in regulations, Mrs. H bears the burden of proving that the reduction is inappropriate under the new regulation. That is, she must prove by a preponderance of the evidence that D requires more than the regulation's presumptive maximum of twelve hours of day habilitation to protect her health and safety and to prevent institutionalization.

1. *Are more than 12 hours per week of day habilitation services necessary to protect D's health and safety?*

There is ample evidence in the record to support the conclusion that D's current day habilitation hours – which exceed that 12-hour cap – are necessary to protect her health and safety. She requires one-on-one assistance to perform rehabilitative exercises at the gym. These exercises are physician- and therapist- ordered and part of an ongoing health strategy to maintain health and prevent further decline. Her day habilitation services also protect and support her mental health and development, providing opportunities in the community to practice interaction and decision-making skills that her TBI has impaired. And the services are necessary for safety. D's TBI has left her with a lack of safety awareness and problem-solving skills that preclude her from being left alone. In order to maintain and continue improving her health, she requires the supervision afforded by day habilitation.

A review of the hearing recording supports that the Division essentially conceded the issue of health and safety. Both Ms. Cobo and the Division's only witness testified that the decision was based on the lack of risk of institutionalization. D's neuropsychologist expressed that if her hours were reduced, her health would decline. When queried about the neuropsychologist's view, the Division's witness did not deny that health and safety was at risk, but indicated that the additional hours still could

⁴⁵ Specifically, noting that since the hearing was originally held, a dispute had arisen about the applicability of the revised regulation, the May 22, 2018 Interim Order asked the parties to address the appropriate interpretation of the regulation as of the time of D's plan of care renewal. The Division's response argued that the regulation should be applied as written; Ms. H's family did not respond.

⁴⁶ 7 AAC 49.135.

⁴⁷ See 42 C.F.R. 431.220(b).

not be authorized unless D was *also* at a risk of imminent hospitalization.⁴⁸ Likewise, Ms. Cobo suggested that the only issue in denying hours over the cap was that the plan of care does not show a risk of institutionalization.

2. *Does D require more than 12 hours per week of day habilitation services to prevent institutionalization?*

As described above, the day habilitation hours D receives beyond the new twelve hour “soft cap” are not only beneficial to her, but truly necessary to protect her health and safety. However, neither the testimony presented at hearing, nor the documentary evidence in the record, establishes that reduction of these services will increase D’s risk of institutionalization.

As a threshold matter, while the revised regulations limit the number of weekly habilitation hours to twelve unless more is necessary to protect the recipient’s health and safety and prevent institutionalization, the regulations do not define or quantify the risk of institutionalization associated with this exception. Mr. Haroun indicated he had applied a standard of whether withdrawal of services would lead to “an immediate risk of institutionalization.”⁴⁹ Ms. Cobo likewise urged that this standard – immediate or imminent risk – governed the analysis and limited the Division’s discretion to authorize additional hours beyond the twelve-hour cap. Neither Ms. Cobo nor Mr. Haroun identified the source of this assumed “immanency” requirement. And, as prior recent OAH decisions on this issue have observed, the revised regulation does not include such language or suggest such a standard. The language of the regulation speaks to additional hours being required to prevent institutionalization, but does not reference or suggest that the risk of institutionalization must be imminent. Thus, as in *Matter of L.D.*, OAH Case No. 18-0011-MDS (2018), and for reasons discussed in detail in that decision, the standard to be applied here will be whether reduction of D’s day habilitation hours to the twelve-hour cap would create a risk of institutionalization during the plan year.

The evidence at hearing does not support a finding that the additional hours are necessary to meet this standard. Mrs. H testified that at various points over the prior plan year, D went without day habilitation for periods of weeks or months at a time due to staffing issues. While these absences were disruptive and caused some backtracking of skill development, there is no evidence that they implicated critical behaviors that would give rise to a risk of institutionalization. D’s providers submitted letters in support of continuing services above the twelve-hour cap, but those letters focused on the beneficial effect of those services on D’s health and safety. Even read in the light most favorable to D’s request,

⁴⁸ Division case presentation.

⁴⁹ Haroun testimony.

these letters – while strongly supporting D’s medical and developmental needs for her existing hours of service – do not suggest a link between those services and the possibility of institutionalization.

Obviously, the question whether withdrawal of services might lead to institutionalization is necessarily a speculative inquiry, and puts the recipient into the difficult position of trying to prove that something that has never happened – because services have been in place – might happen upon their withdrawal. Plainly, this is a difficult burden to meet. In this case, there is simply insufficient evidence in the record to support a finding that a reduction in day habilitation to twelve hours per week will create a risk of institutionalization for D.

B. Because the State’s amended IDD Waiver was not approved by CMS until March 20, 2018, the Division was precluded from applying changes to the Waiver to plans of care reviewed before that time.

The foregoing discussion notwithstanding, the Division’s decision to reduce D’s day habilitation hours under the cap imposed by the new regulations cannot be upheld. This is so because, as recently explained in a final decision by the Commissioner’s designee, the State’s IDD Waiver itself was not amended to approve the regulation’s new cap until months after the decision on D’s plan of care.⁵⁰

Briefly, because Medicaid is a cooperative federal-state program, participating states must comply with federal requirements. States’ Waiver plans must be approved by the Center for Medicaid Services, which then must also approve any substantive changes to the Waiver. The imposition of new limits on day habilitation hours for IDD waiver recipients is plainly a substantive change to the IDD Waiver. For recipients like D, and as the above discussion demonstrates, these limitations represent a significant, substantive change in the Waiver services they receive. Such changes cannot be implemented without federal approval by CMS.

The most recent changes – including the placement of “service limits of Day Habilitation” – were approved by CMS with an effective date of March 20, 2018.⁵¹ Because the Division’s partial denial of D’s day habilitation hours was based solely on substantive changes to the State’s IDD Waiver that predated the effective date of CMS’s approval of those changes by several months, the Division’s decision cannot be upheld.

IV. Conclusion

The evidence presented at hearing supported the conclusion that more than twelve hours per week of day habilitation were necessary to protect D’s health and safety, but did not show that such

⁵⁰ *Matter of S.J. and O.J.*, OAH No. 17-1193/1194-MDS (Final Decision After Remand, June 2018).

⁵¹ <http://dhss.alaska.gov/dsds/Documents/pdfs/IDD-ApprovedWaivers.pdf>.

services are also necessary to prevent institutionalization. However, the Division cannot enforce substantive changes to the IDD Waiver prior to approval of such changes by CMS. Because such changes were not approved by CMS until March 2018, the Division erred in applying them to D's December 2017 plan of care renewal. For this reason, the Division's decision is REVERSED.

Dated: June 14, 2018

Signed

Cheryl Mandala
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 29th day of June, 2018.

By: *Signed*

Name: Lawrence A. Pederson
Title: Administrative Law Judge/OAH

[This document has been modified to conform to the technical standards for publication. Names may have been changed to protect privacy.]