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

In the Matter of	)	
	)	
S.G.	)	OAH No. 22-0813-MDS
	)	Agency No.

FINAL DECISION AFTER REMAND

I. Introduction

Medicaid recipient S.G. experiences serious, life-threatening mental and physical health disorders, coupled with significant side effects of powerful psychotropic medications. He has resided in a long-term care (LTC) facility in City A since 2019.

In August 2022, the Division of Senior and Disabilities Services notified Mr. G. of its determination that he was no longer eligible for Medicaid "skilled or intermediate nursing care." Through his representative, Mr. G. requested a hearing to challenge the Division's finding.

The evidence at hearing established that Mr. G.'s need for continuous monitoring, supervision, and intervention by skilled providers to manage multiple long-term physical and mental health concerns – some of which would be life-threatening in the absence of that ongoing care – continue to satisfy the Medicaid eligibility requirements applicable to nursing facility services. Accordingly, the Division's determination finding him ineligible is reversed.

II. Facts and Procedural Background

S.G., a lifelong resident of Southeast Alaska, was an outgoing and talented young man who developed schizophrenia in his twenties.[1] He has lived at Care Facility since a hospitalization in 2019. This case concerns whether his physical and mental health needs continue to rise to a level of severity warranting nursing facility level of care.

A. Mr. G.'s care needs

Mr. G., now in his early sixties, experiences multiple serious and impactful physical and mental health concerns, primarily arising out of or related to his schizophrenia and its treatment. In addition to schizophrenia, his diagnoses include psychogenic polydipsia, major depressive disorder, extrapyramidal movement disorder, tardive dyskinesia, hyponatremia syndrome, hypo-

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[1] Testimony of K. G..

osmolality, insomnia, conversion disorder with seizures or convulsions, anxiety disorder, COPD, right eye blindness, and left eye glaucoma.[2]

1. Mr. G.'s main physical and mental health concerns

Psychogenic polydipsia. Mr. G.'s psychogenic polydipsia – excessive drinking of water which is not driven by a physiological need – is associated with his schizophrenia, and has potentially life-threatening physical consequences without proper treatment and close monitoring.[3] If his access to fluids is not closely monitored and restricted, Mr. G. will continue drinking water to the point of hyponatremia and hypo-osmolality – dangerously low levels of sodium and electrolytes, respectively, in the bloodstream.

As these conditions worsen, they produce an escalating range of symptoms which progress from headaches to thought problems to balance issues to life-threatening seizures.[4] Other possible risks of improperly controlled psychogenic polydipsia include hallucinations, psychosis, and brain damage.[5]

When his psychogenic polydipsia has been poorly managed in the past, Mr. G. has had dangerously low sodium levels leading to multiple hospitalizations.[6] To prevent this outcome, Mr. G. is on strict fluid intake restrictions at Care Facility.[7] In addition to close monitoring of his fluid intake throughout the day, he requires frequent redirection and education to address his "constant" attempts to circumvent his fluid restrictions.[8]

Hallucinations. Mr. G. also suffers both auditory and visual hallucinations from his schizophrenia.[9] His auditory hallucinations frequently include "mean" voices directing him to self-harm.[10] The impact of schizophrenia on Mr. G.'s functioning is extreme.[11] Nursing staff closely monitor him throughout the day both for behavioral issues and physical safety, and the LTC facility nurses interact frequently with Mr. G.'s psychiatrist to update him on their

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[2] X. N. testimony; M. B. testimony; B. J. testimony, Ex. 7, p. 1.
[3] N. testimony; J. testimony.
[4] N. testimony; B. testimony.
[5] N. testimony.
[6] N. testimony; Ex. 12, p. 6; Ex. 14, AR 191. Indeed, Mr. G.'s stay at the Care Facility began with a seizure that was believed to be caused by uncontrolled psychogenic polydipsia. N. test.; Ex. 12, p. 6.
[7] N. testimony; B. testimony.
[8] J. testimony; E. testimony.
[9] N. testimony; J. testimony.
[10] Dr. N., who specializes in the treatment of patients with severe mental illness, identified Mr. G. as his patient requiring the most interventions and involvement. N. testimony.
[11] N. testimony.

observations and concerns.[12] Mr. G.'s hallucinations and behavioral outbursts require monitoring, redirection, and "PRN" (as needed) medication to treat acute symptoms.[13]

Mr. G. takes significant amounts of antipsychotics and antiseizure medication to minimize his longstanding problems in these areas. In his first two years at the Care Facility, Mr. G.'s medical team "often" made changes to his psychiatric medication regimen while trying to find an appropriate balance of medications to control symptoms while managing side effects.[14] At some point in 2022, "things finally reached a point where things weren't perfect but they were tolerable enough" to stop changing medication.[15] His psychiatrist considers Mr. G.'s medication "a moving target," and "not perfect," but currently "tolerable." However, even at a near maximum daily dose of both antipsychotics and antidepressants, Mr. G. still experiences distressing auditory hallucinations,[16] "agitation outbursts," and "manic episodes."[17]

Medication side effects. Medication side effects are a significant contributor to Mr. G.'s overall health status. He experiences both extrapyramidal movement disorder and tardive dyskinesia – both of which are movement disorders caused by long-term exposure to antipsychotic medications.[18] There is also evidence that Mr. G.'s psychogenic polydipsia – which in turn is responsible for his hyponatremia – developed in the context of a medication side effect.[19]

Further challenges are presented by the complex interactions between the medications prescribed to him for his schizophrenia, anxiety, depression, seizures, and insomnia. For example, anti-psychotic medications for schizophrenia and hallucinations can cause insomnia and muscle movement disorders, while medications for insomnia can exacerbate depression. As a result, his medication regimen has historically required frequent adjustment.[20]

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[12] N. testimony; J. testimony.

[13] J. testimony. Ms. J. testified that Mr. G. required PRN Ativan to control acute symptoms six times in December 2022, and twice in January 2023. Records from August and September 2022 similarly showed fluctuation in Mr. G.'s need for PRNs, sometimes requiring them three times in a seven-day period, and other times less than once per week. Ex. 25. Records from January through October 2022 also show periodic administration of Ativan in the context of agitation and hallucinations – as well other incidents in which nursing staff evaluated Mr. G.'s mental health symptoms and elected to provide non-medical interventions. Ex. 6.

[14] N. testimony.

[15] N. testimony.

[16] N. testimony; Ex. 6, ALSC Bates Nos. 45, 50, 51, 55, 56, 57, 60, 62, 75, 78.

[17] B. testimony; Ex. 6, ALSC Bates Nos. 51, 54, 56, 59, 62, 64, 77, 78.

[18] N. testimony; E. testimony; J. testimony; Ex. 20, p. 2.

[19] Mr. G.'s sister testified that he began abruptly displaying symptoms of this condition in 2019 during a time of multiple difficulties with medication side effects. Testimony of K.G.

[20] J. Testimony; E. testimony; N. testimony.

2. Assistance with activities of daily living

Separate from his significant behavioral health needs, Mr. G.'s medical conditions, including side effects caused by his medications, impact his independent performance of activities of daily living. The muscle movement disorders caused by Mr. G.'s long-term use of psychotropic medications cause "extreme constant moving," including shaking in his hands, and impair his motor function control.[21] They also impact his mobility – both by impacting his joint mobility and by creating balance issues.[22]

Mr. G. requires and receives assistance with various activities of daily living throughout the day.[23]

- *Locomotion.* Mr. G. is too physically unstable to walk, so he uses a wheelchair to locomote between rooms.[24] While he is mostly able to propel his wheelchair on his own, he needs physical assistance at least once or twice each day to push the chair because he gets stuck or has difficulty moving over certain surfaces. Specifically, he is unable to propel his chair over small bumps or seams in the hallway, and requires weight-bearing physical assistance to move the wheelchair past these.[25] This has been "getting harder for him," and can happen up to ten times per day on days when he is actively moving around the facility.[26]
- *Transfers.* Mr. G. requires hands-on physical assistance to move to a chair or couch from his wheelchair.[27] He does not require this assistance if there is a grab bar, such as at his bed. But he requires it to move onto furniture such as a couch or chair, where no grab bar is present.[28]
- *Toileting.* Mr. G. also requires hands-on physical assistance with the hygiene tasks of toileting. While a physician's progress note in his chart describes Mr. G. as "independent in toileting," Care Facility direct care

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[21] J. testimony.

[22] J. testimony; N. testimony.

[23] Care Facility Nurse B. J. and Nursing Director M. E. provided credible testimony about Mr. G.'s functioning and the specific assistance provided to him by the providers at Care Facility. To the extent their testimony may vary from numerical scores listed on other records, such as on the LTC-01 form and some "MDS data sheets" submitted to the Center for Medicare & Medicaid Services (CMS), more weight is given to the testimony of Mr. G.'s care team than to forms on which the factual basis for scores was unclear. Further, as noted herein, the MDS data sheets in the record largely appear to support the testimony of Mr. G.'s care team.

[24] J. testimony.

[25] J. testimony, E. testimony. Ms. E. observed him twice needing physical assistance with this task on the day before her testimony. *See also*, Ex. 23 at 437-438 (MDS data sheets for locomotion, showing 8 instances of "complete dependence" on staff for locomotion between 1/12/23 and 2/6/23).

[26] J. testimony.

[27] J. testimony

[28] J. testimony. *See also*, Ex. 23 at 441-442 (MDS data sheets for transfers, showing 4 instances of either "extensive assistance" or "complete dependence" on staff for transfers between 1/12/23 and 2/7/23).

staff testified credibly and in detail about the assistance provided to him.[29] Staff provides safety monitoring for transfers to/from the toilet. However, because of hand shakiness and impaired motor function control caused by tardive dyskinesia, he always requires hands-on physical assistance to clean his peri-area and buttocks after defecation.[30]

- *Dressing.* Mr. G. requires hands-on assistance dressing his lower extremities – specifically, with donning a pull-up, pants, and shoes.[31] He needs this help because he loses his balance, and because of a lack of motor control.[32]
- *Eating.* Mr. G. requires set-up assistance and supervision for meals, but is currently independent with the actual physical act of eating, notwithstanding his Tardive Dyskinesia and extra-pyramidal movement disorder.[33]
- *Bathing.* Mr. G. requires hands-on physical assistance with washing while showering, getting in and out of the bath, drying off and dressing after a shower, and applying a medicated cream after showering.[34]
- *Medication management.* Mr. G. has "a complex medication regimen" including powerful anti-psychotics as well as multiple PRN medications, and takes medication four times daily.[35] He is unable to self-administer any medications independently without assistance.[36]

Mr. G. also receives restorative range-of-motion exercises five times per week, performed by a CNA trained in restorative therapies.[37]

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[29] *Compare* Ex. 7, 8/25/22 Progress Note *with* J. testimony, E. testimony. Because the physician is not directly involved in this aspect of Mr. G.'s care, the testimony of nurses J. and E. is afforded more weight on this topic. *See also*, Ex. 23 at 439-440 (MDS data sheets for toileting, showing 10 instances of either "extensive assistance" or "complete dependence" on staff for toileting between 1/12/23 and 2/7/23).

[30] J. testimony. Nurse J., who works with Mr. G. daily, observed that these difficulties "are getting harder for him."

[31] J. testimony.

[32] J. testimony; E. testimony. *See also*, Ex. 7, 8/4/22 O. letter: "He needs limited assistance with bathing and dressing."

[33] J. testimony; E. testimony.

[34] J. testimony; *see also*, Ex. 6: 2/10/22 note: "He was receptive to hands on care with a shower with no problems"; 5/19/22 note: "staff provided a shower for him"; and notes on 5/26/22, 6/29/22, 6/30/22, 7/11/22, 7/13/22, and other dates. that "Resident was cooperative with cares," "allowed other care," et cetera; Ex. 7, 9/22/22 note: "S.Q.G. had a shower this morning facilitated by CNA." *See also*, Ex. 7, 8/4/22 S.O. letter: "He needs limited assistance with bathing and dressing."

[35] Ex. 1; Ex. 3; B. testimony; R. G. testimony; E. testimony.

[36] B. testimony.

[37] J. testimony.

3. Current Care at Care Facility

Mr. G. was admitted to Care Facility in August 2019, after being hospitalized following an unwitnessed fall believed to be caused by hyponatremia-related seizures.[38] He has resided in the 19-bed skilled nursing facility continuously since that time, except for periods of acute hospitalization.

Mr. G.'s medical care at Care Facility is overseen jointly by primary care physician M. B., who sees him at least every 60 days,[39] and psychiatrist X. N., who generally sees him monthly.[40] His daily care is provided by nurses and CNAs at the LTC facility. Director of Nursing M.E., who supervises the nurses and CNAs at Care Facility, indicated that her team works with Mr. G. on his schizophrenia, psychogenic polydipsia, tardive dyskinesia, hyponatremia, insomnia, and anxiety "on a daily basis."[41]

The care provided by the Care Facility care nurses includes the following:

- The LTC facility nurses not only administer Mr. G.'s medications, but also, critically, monitor him for medication efficacy and side effects – tasks that are outside the scope of CNAs' training.[42]
- Mr. G.'s nurses are also actively involved in the "constant" monitoring and restriction of fluid intake necessitated by his psychogenic polydipsia.[43] His nursing notes reflect nurses' frequent reminders and redirection, as well as documenting Mr. G.'s frequent attempts to evade these restrictions.[44]
- Likewise, because Mr. G.'s schizophrenia causes auditory and visual hallucinations, nursing staff closely monitor Mr. G. for behavior indicative of this concern, provide both redirection and additional PRN medication as needed, and monitor him closely after these interventions.[45]

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[38] *See* Ex. 12. Mr. G.'s sodium level on admission was 119, a level constituting "severe" hyponatremia and considered life-threatening. Ex. 12; B. testimony. Mr. G., who lived alone at the time, was initially "found down at home" by family members who'd gone to check on him. The initial intake report from his August 2019 hospital admission reflects that "there had been concern about the adequacy of his living situation in supervision given his recurrent admissions for hyponatremia from psychogenic polydipsia." Ex. 12, p. 3.

[39] B. testimony; Ex. 9.

[40] N. testimony.

[41] The Care Facility staff includes nine nurses and more than twenty CNAs, as well as auxiliary staff. Each 12-hour shift includes two nurses, and each 8-hour CNA shift includes three CNAs. E. testimony.

[42] N. testimony; B. testimony; E. testimony. There are some situations in which a CNA under the supervision of a nurse may administer basic medications, but Care Facility does not allow CNAs to perform this task because CNAs are not trained to administer medication. E. testimony. Even at facilities which do allow supervised CNAs to administer more basic medications, CNAs – who also receive no training in monitoring medication side effects – cannot administer antipsychotics or narcotics. E. testimony (describing Assisted Living Facility).

[43] J. testimony; E. testimony (estimating "close to 100" such interactions throughout the day).

[44] N. testimony, Ex. 6.

[45] J. testimony, E. testimony.

Both Dr. N. and Dr. B. believe that Mr. G.'s medical needs are sufficiently complex to require observation and supervision by professional nursing staff.[46] In terms of the near-constant monitoring and redirection provided by skilled nursing staff, Dr. B. believes that Mr. G.'s nurses' experience and training enables them to pick up on behavioral cues that less skilled providers might miss, and to skillfully provide appropriate interventions.[47]

Nursing Director M.E. explained that nurses' specialized training in behavioral health enables them to identify symptoms of distress, noting that following his testimony in this hearing Mr. G. experienced heightened anxiety requiring a nursing intervention with PRN medications.[48] In addition to using PRN anti-anxiety medication when that is indicated, Mr. G. has also occasionally required periodic short-term changes to his other medication dosages in situations where his nurses have contacted Dr. N. about their observations and concerns. Dr. N. relies on their training and expertise to monitor Mr. G. in this manner, and to report to him about changes in his condition in between his monthly visits with Dr. N..[49]

B. City A Long Term Care facility LTC admission and recertifications

1. <u>Initial admission</u>

When Mr. G. was admitted to Care Facility in August 2019, the facility evaluated his physical and mental health, and obtained authorization from the Division that he met nursing facility level of care (NFLOC), making him eligible for admission under Medicaid.

The evaluation conducted at that time included the Pre-Admission Screening and Resident Review (or "PASRR"), required by federal regulations when an individual with mental illness or related conditions is placed in a long-term care facility.[50] The PASSR screening process includes an evaluation of an applicant's medical history, psychiatric history, current symptomology, mental status and functionality.[51] In Mr. G.'s case, the PASSR noted that he experiences auditory hallucinations and paranoid delusions, addressed his need for assistance with various aspects of self-care, and recommended nursing home services.[52]

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46 N. testimony; B. testimony.

47 B. testimony. When queried by the Division about whether a CNA could perform these same tasks, Dr. B. expressed concern that CNAs would not have the experience to understand and respond to Mr. G.'s "waxing and waning" mental health symptoms.

48 E. testimony.

49 N. testimony; Ex. 18, ALSC No. 407, 408.

50 Ex. 15; 42 C.F.R. 483.100-483.138.

51 Care Facility completed both a Level I and Level II PASSR for Mr. G., with Level I being required for all LTC applicants, and Level II specifically addressing an applicant's cognitive and behavioral health needs.

52 Ex. 15.

At the time of Mr. G.'s admission and periodically thereafter, Care Facility submitted the Division's Long-Term Care (LTC) Facility Authorization Request form, referred to as the "LTC-01." The LTC-01 is a four-page form containing much less detail than the PASSR. After a section of identifying information, Section 2, "Discharge Planning," asks the facility to identify the supports the resident would need for community placement, why alternative placement is not feasible/appropriate, and what plan exists for discharge. Section 3, "Physician Certifications," asks for primary, secondary, and additional diagnoses; the medical reasons for continued stay; and the physician's level of care recommendation and intended length of stay. Section 4, "Individual Needs," then contains:

- a chart to list medications, dosage, and purpose.
- a chart listing nine self-care activities – medication management, bed mobility, transfers, locomotion, dressing, toilet use, personal hygiene, bathing, and eating – with spaces to indicate a self-performance score and a support score for each. A generalized description of the bases for various scores is provided, although the listed activities themselves are not specifically defined.
- five check boxes under the header "Cognition;" as to each item – short-term memory, long-term memory, orientation, cognitive abilities, and decision making – there are boxes to check either "OK" or "Problem," and a space after "Problem" to enter a description.
- four check boxes under the header "Therapy Services" – physical therapy, speech-language therapy, occupational therapy, and other – with a box after each to list number of days per week.

At Care Facility, the LTC-01 is filled out by the staff social worker and submitted to the Division along with updated medical records and progress notes.[53]

Shortly after his admission to Care Facility, an LTC-01 for Mr. G., dated August 26, 2019, scored him as needing complete support for medication management; extensive assistance in the ADLs of locomotion, dressing, toilet use, and bathing; limited assistance in the ADL of transfers; and supervision/set up help for personal hygiene and eating.[54] He was also listed as receiving physical therapy, occupational therapy, and speech-language therapy between 4-7 days per week.[55] The narrative description of support needed, within the discharge section, describes:

> Mr. G. requires observation, assessment, and treatment of an unstable condition requiring skilled nursing services with professional medical or nursing

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53 C. testimony; Ex. 16 at AR 873, 879 (noting attachment of MD visit notes and RNA and RN progress notes), AR 299 (same, as well as "social work discharge planning notes").

54 Ex. 16, AR 210-211.

55 Ex. 16, AR 210.

supervision. Patient requires extensive assistance with his medication management, mobility and activities of daily living due to his parkinsonism, psychogenic polydipsia, and schizophrenia.[56]

The medical reason for continued admission was identified as Mr. G.'s need for "assistance managing medications and psychiatric care as well as assistance with ADLs."[57]

2. Subsequent recertification requests

Subsequently, Care Facility submitted periodic reauthorization requests on Mr. G.'s behalf to the Division, and the Division approved his continued placement there.[58] For each request, the facility submitted a new LTC-01 form.

An LTC-01 dated August 11, 2020 – and prepared by a different employee than the employee who prepared the August 2019 form – provided very different scores on the "Capacity for Independent Living and Self-Care" section. The August 2020 form described Mr. G. as needing no more than set up help on any ADL other than medication management, which was still listed as "total dependence."[59] At the same time, the 2020 form described Mr. G. as requiring "observation, assessment, and treatment of an unstable condition, specifically, medication management, mobility and activities of daily living due to his parkinsonism, psychogenic polydipsia, and schizophrenia."[60] And the medical reason for continued admission was Mr. G.'s need for "assistance managing medications, psychogenic polydipsia, mobility, and some ADLs."[61] The Division processed this reauthorization request as "approved as requested."[62]

An LTC-01 dated February 4, 2021, prepared by the same employee who had prepared the August 2020 form, again described Mr. G. as needing only "set up" assistance on ADLs, other than medication management, for which he was described as totally dependent on staff.[63] At the same time, Mr. G. was described as requiring "observation, assessment, and treatment of an unstable condition, specifically, medication management, mobility and some ADLs due to his

[56] Ex. 16, AR 208.
[57] Ex. 16, AR 209.
[58] Ex. 16; C. testimony.
[59] Ex. 16, AR 0867-0868.
[60] Ex. 16, AR 866.
[61] Ex. 16, AR 867.
[62] Ex. 28, AR 875. There was also an earlier LTC-01 submitted in February 2020; that LTC-01 is not in the exhibits, but the Division's approval, processing the request "approved as requested," is. *Id.*, AR 1274.
[63] Ex. 16, AR 872-873. The now-former employee who prepared the earlier LTC-01 forms did not testify at the hearing.

Parkinsonism, Psychogenic Polydipsia, and Schizophrenia."[64] The section for listing "Medical Reason for Continued Stay" read: "Resident needs assistance managing his medications, psychogenic polydipsia, mobility, and some ADLs."[65] The Division's LTC Authorization Determination form for this request indicates it was processed, "Approved as Requested."[66]

3. Division's notification to Care Facility – but not Mr. G. – of its determination that NFLOC was not met

In early 2021, the Division informed Care Facility (via an electronic medical communication network called Harmony) that it believed Mr. G. no longer met "nursing facility level of care," but that he was "conditionally approved" for continued placement due to the lack of safe, alternative discharge options.[67] However, neither Mr. G. nor his power of attorney, his mother T. G., were copied on this communication, and they did not learn of it until much later.[68]

4. 2022 recertification requests

In February 2022 and again in July 2022, Care Facility submitted further LTC authorization requests for Mr. G. On the "Individual Needs" section of these requests, Mr. G. was described as totally dependent on others for medication management, but otherwise requiring only "set up" help for the various listed ADLs.[69] Mr. G. was described as having problems with regard to cognitive abilities and decision-making, receiving "RNA" therapy services five days per week, and nursing therapy services – specifically, "medication management [and] management of psychogenic polydipsia" – seven days per week.[70]

Both 2022 authorization requests stated that Mr. G. "requires observation, assessment, and treatment including medication management, mobility, and some ADLs due to his Parkinsonism, Psychogenic Polydipsia, and Schizophrenia."[71] In terms of whether Mr. G. could

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[64] Ex. 16, AR 871.

[65] Ex. 16, AR 872.

[66] Ex. 28, AR 1375.

[67] *See* Ex. 17, p. 2 (ALSC Bates No. 394); Ex. 7 (8/422 O. letter); Ex. D (denial letter). The Division apparently made its determination that Mr. G. did not meet NFLOC in 2020. Testimony of T. D..

[68] S. G. testimony; testimony of T. D. ("there was no denial notice").

[69] Ex. 16 (AR 879, 884-885). The February 2022 request, at AR 876-880, sought coverage from March 2022 through August 2022. The July 2022 request sought coverage for September 2022 through February 2023. AR 882-886.

[70] Ex. 16, AR 876-880 (Feb); AR 0882-0886 (July). Care Facility submitted an amended request for the November 2022-April 2023 period in September 2022. H. C. submitted the amended request after taking over the social worker position. Ms. C. scored Mr. G.'s need for assistance with various self-care tasks as follows: Transfers: 1/0; Locomotion: 1/0; Toilet Use: 1/1; Dressing: 3/2; Personal hygiene: 3/2; Bathing: 3/2. It also noted that Mr. G. was totally dependent on staff for medication management, and received therapy services from "MD, RNA, MD, SW" seven days per week. Ex. 16, AR 313-317.

[71] Ex. 16, AR 876-880 (July 2022 request); 882-886 (February 2022 request).

be placed in another facility, both requests indicated that "the above level of care is not available elsewhere in his current community [and] there are not other community support systems sufficient to meet his needs."[72]

Like the authorization requests dated February 2020, September 2020, February 2021, August 2021 – and despite apparently having determined that Mr. G. did not meet NFLOC sometime in 2020 – the request dated February 2022 was processed as "Approved as Requested."[73]

C. Division's August 2022 denial of long-term care authorization for Mr. G.

On August 22, 2022, the Division sent a letter captioned "Partial Denial of Nursing Facility Long Term Care (LTC) Authorization" to Mr. G. and his power of attorney.[74] This letter, addressing the July 2022 reauthorization request, was the first time Mr. G. or his power of attorney were notified of the Division's position regarding his eligibility. It stated:

> After review of the request, the [Division] has determined that the information submitted as part of the Application for Long Term Care Facility Authorization does not sufficiently document the need for skilled or intermediate nursing care. The request is authorized for dates of service 9/01/2022 to 10/31/2022 to allow additional time for discharge. The remaining dates of service originally requested, 11/01/2022 to 02/28/2023, are denied. See 7 AAC 140.500, 7 AAC 140.505, 7 AAC 140.510, 7 AAC 140.515, 7 AAC 140.535. [75]

The letter went on to indicate that its purpose was, in part, to "explain the reason for this denial and why it appears that you do not meet Nursing Facility Level of Care."[76]

1. <u>How the Division assessed Mr. G.'s eligibility for long-term care services</u>

Under a heading captioned "How was this decision made?," the Division's August 2022 letter stated that in order for Medicaid to pay for a recipient to stay in a nursing facility or hospital nursing facility, the recipient "must have medical needs that require the level of care provided" in these facilities.[77] The letter then stated that Mr. G.'s eligibility for nursing facility

[72] Ex. 16, AR 876-880 (July 2022 request); 882-886 (February 2022 request).

[73] Ex. 28, AR 1274, AR 875, AR 1375, AR 0881, AR 887. Once again in February 2022, the Division apparently communicated to Care Facility – but not to Mr. G. or his representatives – that it considered the February 2022 reauthorization to be a "conditional authorization." The authorization determination form, however, is simply marked "Approved as requested." Ex. 28, AR 887.

[74] Ex. D.

[75] Ex. D, p. 1.

[76] Ex. D, p. 1.

[77] Ex. D, p. 2, citing 7 AAC 140.500, 140.510, and 140.515.

level of care had been determined by reviewing the July 2022 LTC-01, along with documentation from Care Facility about the following topics:

- "Medical reason for admission to a Nursing Facility/Hospital Nursing Facility;"
- "How much help you need with nursing care;"
- "How much help you need with activities of daily living, like eating, moving between your bed and chair, using the toilet, moving about in bed, and getting around in your living environment;"
- "How much physical, occupational, or other therapies you are receiving;"
- "Whether your overall condition is relatively stable or unstable."[78]

The letter also included a list of specific documents reviewed by a Division assessor.[79]

The letter then described: (1) that at the time of his initial admission to Care Facility, Mr. G. had required assistance with ADLs as well as physical therapy, occupational, and speech therapy, but (2) that he was discharged from therapies in 2020, and described at that time as able to "perform all of his ADLs independently with the exception of dressing, bathing, and medication management." The letter then added, without citation, that "none of these ADLs have bearing on the NFLOC eligibility requirements."[80]

2. The Division's use of "CAT principles" in its determination

While the letter contains no explanation or legal citation for its statement about certain ADLs not being relevant to Mr. G.'s NFLOC eligibility, it became apparent at hearing that this statement related to an assessment tool used in applications for Medicaid Home and Community-Based Waiver services. As described by one of the two Division nurse assessors assigned to review long-term care authorization requests, the Division uses the Consumer Assessment Tool, or "CAT," to guide it in making level of care determinations related to Long-Term Care.

The CAT is an assessment instrument developed by the Department of Health for use in assessing Medicaid recipients' eligibility for Home and Community-Based Waiver services, and adopted into regulation for that purpose.[81] The one- to two-hour long CAT assessment is conducted by trained Division assessors who score recipients on a broad range of factors including their ability to perform a range of activities of daily living, and the amount of and type

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[78] Ex. D, p. 2

[79] Ex. D, pp. 2-3.

[80] Ex. D, p. 3.

[81] *See* 7 AAC 130.215. The Home and Community-Based Waiver program pays for services that allow individuals who meet nursing facility level of care to stay in their home or an assisted living facility, rather than move into a nursing facility. Mr. G. is not a Waiver recipient.

of assistance they need in order to do so.[82] Each individual score is derived "based on the assessor's observations," the recipient's medical records, and the recipient's reports, and scored pursuant to the applicable scoring matrix set out within the CAT document. Individual scores on ADLs and other areas – including cognitive capacity, behavioral functioning, and need for skilled nursing services – are then tabulated under the CAT's specific guidelines to determine a particular recipient's eligibility for services.[83]

Those guidelines, set out within the CAT, provide multiple paths by which an individual can meet nursing facility level of care. Relevant to this case, a person meets nursing facility level of care if they require weight-bearing support three or more times per week in performing at least three of the following activities of daily living: bed mobility, eating, locomotion, transfers, and toilet use (the "shaded" or "BELTT" ADLs).[84] And a person also meets nursing facility level of care if they require either non-weight bearing physical assistance or weight-bearing support three or more times per week in just two of the BELTT ADLs, while also requiring certain skilled nursing services and/or experiencing certain cognitive or behavioral health challenges.[85]

Although the Division uses the CAT "for guidance" in its long-term care authorization decisions, it is undisputed that the Division never conducted an actual CAT assessment on Mr. G., and no CAT document exists for him. Instead, the Division "applied the guidelines within" the CAT to make its level of care determination.[86] In essence, the Division superimposed CAT scoring principles on the Long-Term Care authorization form and other medical records submitted by the long-term care facility.

In conducting this exercise, the Division relied on the ADL performance scores set out in the Long-Term Authorization form to conclude that Mr. G. "can perform all of his ADLs

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82 Testimony of T. D.

83 D. testimony. A blank copy of the 32-page CAT, referred to hereafter as "Sample CAT," can be found online at http://www.alaskaccn.com/files/QuickSiteImages/BlankECAT.pdf (last visited 7/18/23).

84 Under qualifying question NF6, the assessor is asked how many of the BELTT ADLs in the assessment "were coded with a 2, 3, or 4 in self-performance AND required a one or more physical assist in support (support coded as 2 or 3)?" Sample CAT, p. 31. Self-performance codes of 2 – 4 range from limited assistance with just guided maneuvering of limbs or non-weight bearing assistance 3 times per week and weight bearing twice per week, through total dependence. Sample CAT, p. 20.

85 Sample CAT, p. 31.

86 D. testimony ("We didn't assess him using the tool, but we applied the guidelines within the tool … that measure level of care;" "We look at the level of care criteria within the CAT, and we use that information to apply to long term care.").

independently with the exception of dressing, bathing and medication management." Superimposing the CAT's use of only the BELTT ADLs in determining whether Waiver applicants meet NFLOC, the Division's letter states that "none of these ADLs [– that is, dressing, bathing, and medication management –] have bearing on the NFLOC eligibility requirements."[87]

The Division ultimately concluded that Mr. G.'s records from Care Facility reflected an ability to perform the BELTT ADLs with no more than supervision, that his "medical issues are managed by his medication regimen," and that the supervision and interventions he was receiving were tasks that did not need to be performed by a skilled nurse.[88] The Division was aware of but not persuaded by: Mr. G.'s command hallucinations, his risk for self-harm, his suicidal ideation, his episodes of agitation, his fluid intake risks, his gait and balance problems caused by his psychoactive medication, his use of PRN anti-anxiety medications, and his complete dependence on others for medication management.[89] In essence, the Division agreed that Mr. G. "requires constant supervision and attendance," but not by "licensed providers."[90]

3. Position of Mr. G.'s current care team

Given the extent to which the nursing team at the LTC helps control his behaviors through close monitoring and redirection, Mr. G.'s care team is skeptical that his or others' safety would be adequately protected without his current level of supervision and monitoring.[91] His current care providers believe that, in a less closely monitored setting, Mr. G. would likely regress – both in terms of "behaviors" generally and in terms of his extremely dangerous overconsumption of water.[92]

A February 2022 "discharge planning" note from Dr. B. stated that Mr. G. "has been relatively stable [at Care Facility] due to his current level of care, which we think is the appropriate level of care for this patient. Given intermittent B[ehavioral] H[ealth] adjustments to

[87] Ex. D, p. 3.
[88] D. testimony.
[89] D. testimony.
[90] D. testimony ("While Mr. G. does have significant mental health issues, we found that he doesn't have any assistance needs with ADLs, cognitively he doesn't trigger that point, while he is being observed we found that the observation required did not require a skilled licensed medical professional so much as someone who can provide 24-hour supervision. Now, we would agree that his type of environment that he can live in and thrive would be very limited, but it doesn't rise to the level of nursing facility level of care as we define it.") That definition, Mr. D. testified, is the level of care identified in the CAT assessment.
[91] J. testimony; N. testimony; E. testimony; B. testimony.
[92] J. testimony; N. testimony.

medication, LTC is the most medically appropriate location for this patient."[93] In an October 2022 letter explaining her view that Mr. G. requires "the level of care consistent with a skilled nursing/long term care facility," Dr. B. noted the following factors:

- Mr. G.'s complex medication regimen, "including psychiatric medications that require close and careful monitoring by trained staff;"
- the need for careful monitoring, 24/7 supervision, and lab level monitoring to avoid "electrolyte derangements and emergency room visits" due to psychogenic polydipsia, and
- Mr. G.'s need for assistance with multiple activities of daily living – as well as the specialized skills required to provide that assistance effectively to a patient with Mr. G.'s psychiatric conditions.[94]

Dr. B. characterized Mr. G. as having been "medically stable and at his highest practicable level of functioning during his time at City A Long Term Care due to the skilled care he receives," and cautioned that moving him to a lower level of care – without the "supervision and observation of symptoms" by professional staff – would place him "at risk of destabilizing psychologically as well as physically."[95]

Dr. N., Mr. G.'s psychiatrist, believes that Mr. G.'s constellation of suicidality, polydipsia and hyponatremia, as well as his need for nursing assistance with medication and activities of daily living, preclude his needs from being met at a lower level of care.[96] Dr. N., in explaining why he "strongly oppose[s] moving him to another level of care," notes that Mr. G. is suicidal and disturbed by voices telling him to kill himself, as well as being on water restriction and requiring daily monitoring from nursing to enforce those restrictions. Like Dr. B., Dr. N. believes that Mr. G.'s medication management – including ongoing observation and monitoring of reactions and efficacy – requires nursing judgment due to Mr. G.'s complex medical and psychiatric symptoms and his particularly severe symptomology. Removing the nursing assistance, medication management, and constant monitoring of Mr. G.'s fluid intake, Dr. N. believes, would likely lead to quick, severe decline.[97]

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[93] Ex. 17, ALSC Bates 396.
[94] Ex. 1.
[95] Ex. 1.
[96] Ex. 2; N. testimony.
[97] N. testimony (removing these supports "would in all likelihood require that he go back into the hospital.").

While efforts have been made to find an alternative placement for Mr. G., "the options are extremely limited,"[98] and no suitable available alternative has been identified. There are no other facilities in City A. that could meet his needs.[99] Care Facility has not been able to identify any assisted living home in Southeast Alaska that Mr. G.'s current team believes is capable of meeting his needs.[100] Mr. G. is on the active wait list for the City B Assisted Living Home, but the Assisted Living Home has not made a determination that it can actually meet his needs.[101]

Based on indications from the Division that it would not approve Mr. G.'s continued placement, Mr. G.'s care team met in June 2022 to discuss Mr. G.'s placement.[102] The team agreed unanimously that Mr. G. should remain in long-term care.[103]

D. Fair hearing request and procedural history

The August 2022 partial denial was the first time the Division had notified Mr. G. or his power of attorney of its position that he no longer satisfied the nursing facility level of care. Mr. G., through his power of attorney, requested a hearing to challenge this determination.[104]

A four-day evidentiary hearing was held by videoconference in February 2023, with Mr. G. represented by Alaska Legal Services Corporation, and the Division represented by an Assistant Attorney General. In addition to Mr. G., testimony was taken from: Mr. G.'s sister, K. G., and mother T. G.; Care Facility Medical Social Worker H.C., Nursing Supervisor M.E., and Nurse B. J.; Drs. M. B. and X. N.; and Division Nurse II T.G..

After the parties submitted post-hearing briefs, the record was closed on March 13, 2023 and the matter taken under advisement. Thereafter, however, and due to unforeseen circumstances, the assigned administrative law judge was unable to complete the decision before his June 2023 retirement. Accordingly, the matter was reassigned to the Deputy Chief Administrative Law Judge, who, after reviewing the full hearing audio, exhibits, and briefing, issued a proposed decision under AS 44.64.060(e).

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98 E. testimony.

99 D. testimony.

100 E. testimony. The only assisted living home in City C. is in a two-story home, which is not an option for Mr. G. due to his wheelchair dependence, even if it were otherwise suitable. E. testimony. Mr. G.'s family also strongly oppose any effort to move him outside of Southeast Alaska. Ex. 17; T.G. testimony. According to Mr. D., the Division does not require a long-term care recipient to move outside their home community.

101 C. testimony.

102 Ex. 17; Ex. 22; Ex. 27; E. testimony. The team had engaged in periodic discharge planning discussions in the summer of 2020 but was unable to identify appropriate placements. *See* Ex. 17, AR 275-276.

103 B. testimony.

104 Ex. C.

The proposed decision concluded that the evidence at hearing established that Mr. G. satisfied the eligibility standards set out by both parties; however, the proposed decision did not squarely address the question of which eligibility standard applies. After the parties were given the chance to file proposals for action under AS 44.64.060(e), the Commissioner of Health's designee in this matter remanded the case for revision of the proposed decision to include an express determination on that larger issue. This final decision now issues.

III. Discussion

The central factual question in this case is whether or not Mr. G. meets nursing facility level of care. In order to resolve this question, we must consider the standard(s) under which to appropriately determine NFLOC in this case.

A. Legal framework

In a fair hearing reviewing a decision by a Division of the Department of Health, the party seeking to change the status quo has the burden of proof.[105] Here, where the Division seeks a finding that Mr. G. no longer meets Nursing Facility Level of Care, the Division has the burden of proving, by a preponderance of the evidence, that its determination is correct.

In this hearing, the matter is heard de novo – that is, based on a full review of all available evidence, rather than based on a more limited review of the evidence available to the Division at the time of its decision.[106] Thus the question is not whether the Division's decision made sense based on the information available to it at the time of the August 2022 letter. Rather, the question is whether or not, based on all the evidence presented at hearing about Mr. G.'s condition at the time of the Division's determination, Mr. G. requires Nursing Facility Level of Care.[107] As the Division seeks to change Mr. G.'s placement, it had the burden of proving by a preponderance of the evidence presented by both sides that Mr. G. does not meet Nursing Facility Level of Care.

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105 7 AAC 49.135.

106 *See, e.g., In re O.E.*, OAH No. 13-0542-MDS (Dep't of Health & Soc. Serv, Kosin, Commissioner's Designee, 2013) (https://aws.state.ak.us/OAH/Decision/Display?rec=2865).

107 *Id.*. Although the hearing was held nearly six months after the Division's determination, Drs. B. and N. both testified that Mr. G.'s condition was essentially unchanged from around the time of the Division's decision. While several witnesses testified that certain tasks seem to be getting more challenging for Mr. G., there is nothing in the record to suggest that any of the factual testimony about his functioning reflects material changes in that functioning after the time of the Division's denial.

B. Nursing Facility Level of Care determinations for nursing facility residents and applicants

The parties disagree, as a threshold matter, about how the NFLOC determination should be made in this context.[108] The Division's August 2022 "Partial Denial of Nursing Facility Long Term Care (LTC) Authorization" notice cited to 7 AAC 140.500, .505, .510, .515, and .535, all found in the Division's "Nursing Facility Services: ICF and SNF" regulations. Mr. G. contends – and this decision holds – that these regulations govern NFLOC determinations for nursing facility recipients.

1. <u>The Division's CAT-based approach is not supportable.</u>

Despite citing only the nursing facility-specific eligibility regulations in its notice, the Division contends that the Nursing Facility Services regulations do not set the eligibility criteria for NFLOC. Instead, the Division posits, the criteria are those used to determine NFLOC in the context of the Medicaid Waiver program.

While Medicaid Waiver eligibility determinations are – by regulation – made using the Consumer Assessment Tool (CAT), the Division does not conduct CAT assessments on nursing facility residents. Nonetheless, without reference to any regulatory authority and despite the fact that Mr. G. has not had a CAT assessment at any point during his time at Care Facility, the Division made its NFLOC determination by "apply[ing] the same criteria" to the long-term care authorization form that it applies to full CAT assessments when making NFLOC determinations under the Waiver program.[109]

Based on its application of those criteria, and relying on the premise that BELTT ADL-related CAT scoring dictates nursing facility level of care determinations not just for the Waiver program but for nursing facility applicants and residents as well, the Division contends that Mr. G. is ineligible to continue receiving intermediate care facility services. Beyond defending this approach as a permissible way to determine whether a non-Waiver recipient is eligible for

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108 A preliminary legal ruling on this issue was made by Judge Lebo shortly before the hearing began. During the hearing itself, however, Judge Lebo later addressed on the record that his order would not be "the final determination on that issue," given the development of the evidence during the hearing, including, notably, the fact that no actual CAT had ever been conducted in this case.

109 D. testimony.

nursing facility level of care, the Division contends that this CAT-analogous scoring is the only way to determine whether a recipient meets NFLOC.[110]

Mr. G. urges that application of this method violates his due process rights in several ways, including a lack of notice and a lack of basis in law. As a legal matter, while the CAT clearly provides a mechanism to determine NFLOC in the context of Waiver applications, its adoption into regulation is limited to the Waiver program regulations. Additionally, of course, the use of the CAT to determine NFLOC even in that context obviously requires that an actual CAT assessment be conducted – a significant missing element here. The Division's LTC-01 form is less detailed than the CAT, and is not prepared by an individual trained by the Division in documentation of factors related to program eligibility and who observes the recipient first-hand. The form also lacks specific scores for items such as cognitive ability, mental impairment, and need for nursing services, each of which is separately scored on in a CAT assessment. In short, there are numerous problems with the Division's approach.

This decision concludes that the Division's proffered methodology is not a permissible one for determining whether NFLOC is met for non-waiver participants. While a CAT assessment, if one had been performed, would be evidence of level of care, the intermediate care and skilled nursing facility regulations currently in effect set forth a broader definition of those services, and thus require a broader inquiry than the Division's method as described in this case.

2. The intermediate and long term care regulations identify the eligibility standards.

The department's nursing facility regulations state that "the department will determine the appropriate level of care by considering (1) the type of care required; (2) the qualifications of the person necessary to provide direct care; and (3) whether the recipient's overall condition is relatively stable or unstable."[111] The next two regulations separately describe intermediate care and skilled nursing care, with the most significant difference being whether the condition being treated is "relatively stable" or "unstable."[112]

Skilled nursing services are those "needed to treat an unstable condition," ordered and directed by a physician, provided by or under supervision of "qualified technical professional

[110] *See, e.g.,* Division's Proposal for Action, p. 2 ("The Division requests the Proposed Decision be modified with the addition of a sentence to this effect: 'The Division used the only correct standard for finding skilled or intermediate nursing care eligibility.['])")

[111] 7 AAC 140.505(a).

[112] 7 AAC 140.510, 515.

personnel," and consisting of "the observation, assessment, and treatment of a recipient's unstable condition requiring the care of licensed nursing personnel to identify and evaluate the recipient's need for possible modification of treatment, the initiation of ordered medical procedures, or both, until the recipient's condition stabilizes."[113] Intermediate care services, in turn, are also physician ordered and directed, but needed to treat a *stable* condition. These services are provided to a recipient who does not require the level of care provided by a skilled nursing facility. They consist (in relevant part) of, "the observation, assessment, and treatment of a recipient with long-term illness or disability whose condition is relatively stable and where the emphasis is on maintenance rather than rehabilitation[.]"[114]

The Division's assertion that these regulations are inapplicable to NFLOC eligibility determinations is not persuasive. Indeed, the Division's notice to Mr. G. in this case cited only these nursing facility services regulations, 7 AAC 140.505, .510 and .515.[115] No reference to the CAT or the standards therein was provided, nor do those standards appear – whether expressly or by reference – in the nursing facility services regulations.[116] This decision agrees with Mr. G. that his eligibility for long-term care must be assessed using the standards set out in the regulations governing the nursing facility services program.[117]

Turning again to the Division's use of the CAT paradigm, this decision does not prohibit the Division from considering medical records and other eligibility-related evidence within the same broad framework that the CAT provides. What is not permissible is the Division's restriction of eligibility using the CAT standards. While a CAT assessment, if one had been

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113 7 AAC 140.515.

114 7 AAC 140.510(b).

115 The Division's reliance on the CAT standard without notice or citation raises due process concerns, as state and federal regulations require that prior to denying, reducing, suspending, or terminating benefits, the Division must provide the recipient with a written notice containing "the reasons for the proposed action, including the statute, regulation, or policy upon which that action is based." 7 AAC 49.070. *See also* 42 C.F.R. § 431.210(c).

116 *See also*, D. testimony (Q: "Was any notice provided to Mr. G. that the CAT assessment was the basis for the standard of whether or not he would meet level of care?" A: "I don't believe so. But the CAT isn't used in Long Term Care; it's specific to the Waiver program").

117 Although Mr. G. was never previously notified of the Division's "conditional authorizations" of his placement, the Division's "Partial Denial" discusses these – and the Division's dissatisfaction with "discharge planning" efforts in light of them – in greater detail than its conclusions about his eligibility. *See* Ex. D, p. 3. In particular, the Division's letter criticized Care Facility's efforts at "discharge planning" in light of the earlier determination that Mr. G. did not meet NFLOC. At the hearing, Mr. D. testified that "the reason for the denial was that they declined to participate in discharge planning." Mr. G., as discussed above, received no prior notice of the Division's earlier determination regarding his eligibility for NFLOC. His (or his representatives') participation in a discharge planning process that the Division believes should have flowed from that determination is not an appropriate basis on which to determine his continued eligibility in this case.

conducted, could be *evidence* of level of care, it would not (in the absence of a regulation to the contrary) be the only such evidence to consider. Nor is it appropriate – again, absent a regulation providing such a path – to limit the scope of the NFLOC eligibility determination to a narrow subset of issues, *i.e.* the BELTT ADLS.

The error of using a CAT-based eligibility paradigm to determine level of care under the nursing facility regulations is that the CAT paradigm is more limited than the nursing facility regulations allow. While the Waiver program regulations pin eligibility directly on the CAT's NFLOC determination, the nursing facility regulations ask more broadly whether the recipient requires professional medical or nursing supervision entailing the ongoing observation, assessment, and treatment of their stable medical condition. The care required and received on specific issues identified within the CAT's NFLOC paradigm is relevant, but not determinative, to this broader question. In other words, satisfying the CAT criteria may be factual evidence that a recipient meets nursing facility level of care, but falling short of the narrow CAT criteria cannot be the basis upon which eligibility is denied. Nursing facility level of care could well be met for a long-term care facility resident who does not meet the narrow BELTT ADL criteria, but whose constellation of needs and physician-ordered services nonetheless reflect a need for medically-supervised "observation, assessment, and treatment" of a long-term illness or disability. It is this broader question that must be assessed in determining whether Mr. G. meets nursing facility level of care.

C. Mr. G. meets Nursing Facility Level of Care.

1. <u>Intermediate care versus skilled nursing care</u>

Within care covered by the intermediate and skilled care facility regulations, a chief difference between levels of care is "whether the recipient's overall condition is relatively stable or unstable."[118] Considerable hearing testimony was addressed to the threshold question of whether or not Mr. G.'s condition qualifies as "stable."

It is clear from the testimony that "stable" can mean many things in the provision of medical and mental health care services. It is also clear from the testimony that Mr. G.'s mental health needs require a great deal of careful monitoring and intervention. However, these needs have been able to be met at an intermediate care facility level (as opposed to a skilled nursing facility level) since 2020, and there was insufficient evidence to conclude that Mr. G.'s needs are

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[118] 7 AAC 140.505(a).

greater than those currently provided.[119] The evidence thus supports a finding that Mr. G.'s condition at the time of the Division's decision – while requiring a great deal of ongoing skilled care, oversight, and management – currently qualifies as "stable" under the meaning of the nursing facility services regulations.

The "stable condition" finding places Mr. G.'s condition within the realm of services potentially covered by the intermediate care facility regulation. In addition to being "needed to treat a stable condition," such services must be physician-ordered and directed, and provided to a recipient who does not require the level of care provided by a skilled nursing facility. The regulation then goes on to define these "intermediate nursing services" themselves, in relevant part, as "the observation, assessment, and treatment of a recipient with long-term illness or disability whose condition is relatively stable and where the emphasis is on maintenance rather than rehabilitation[.]"[120]

2. Whether Mr. G. continues to require professional medical or nursing supervision for which he receives necessary ongoing observation, assessment, and treatment.

In addition to having a "relatively stable" condition for these purposes, the second qualifier – physician ordered and directed care – is also met here. The question under 7 AAC 140.510 is whether Mr. G. "continues to require professional medical or nursing supervision," and for this reason receives necessary "observation, assessment, and treatment" of a long-term illness or disability.

As explained above, in the absence of regulatory authority limiting this analysis to the factors that govern NFLOC under the CAT, neither the CAT nor the CAT eligibility factors control this analysis. To the extent that the same factors used to determine NFLOC in the CAT may be considered alongside other evidence to evaluate and contextualize the level of care a non-Waiver recipient requires, this decision notes that the evidence here supports a NFLOC finding under the CAT criteria. In brief, the CAT's scoring system determines eligibility using a point-based rubric requiring a recipient to receive three or more total points from various

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119 Mr. G. was briefly qualified under Skilled Nursing Facility category, but has been qualified under the Intermediate Nursing Facility category since at least 2020. Ex. 28, pp. AR 1275, 875, 1375, 0881, 887, and E. testimony. While Mr. D. testified that Mr. G. "has been at ICF level coverage, but since 2020 our findings were that he did not meet NFLOC," no notice of such a determination was ever provided to Mr. G., and the Division continued to issue authorizations for ICF under the LTC-01 forms submitted by Care Facility.

120 7 AAC 140.510(b).

categories.[121] As the Division conceded that Mr. G. qualified for one behavior-related point,[122] meeting NFLOC would require only two additional points, with one point given for each BELTT ADL requiring at least "limited" assistance.[123] The evidence establishes that Mr. G. requires this level of support in at least two of the BELTT ADLs – locomotion and toileting[124] – thus establishing a level of behavior and ADL needs that would satisfy the CAT's threshold for NFLOC.

Thus, to the extent that Mr. G.'s functioning in areas that the CAT links to NFLOC for Waiver recipients could be relevant to the broader question of his eligibility for intermediate care facility services, the evidence as to those areas of functioning supports a finding that Mr. G. requires nursing facility level of care. More significantly and more foundationally, however, it is the strong evidence of Mr. G.'s need for constant supervision, monitoring, and intervention by skilled providers that dictates the conclusion that he is eligible for intermediate care facility services.

The Division does not contest that Mr. G. requires round-the-clock supervision. The Division contends that Mr. G. does not require such supervision in a nursing facility because the care provided by Care Facility nurses is, in the Division's estimation, care that could be provided by less skilled providers.[125] However, both of Mr. G.'s medical providers – Drs. B. and N. – strongly believe that he requires professional nursing supervision. Mr. G.'s nursing providers not only administer his medication, but also monitor his reactions to medications – a task for

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[121] A blank copy of the CAT may be found online at http://www.alaskaccn.com/files/QuickSiteImages/BlankECAT.pdf (last visited 7/18/2023). The NFLOC scoring sheet is located at page 31 of the 32-page assessment.

[122] CAT, p. 31. In the NFLOC scoring section, Question NF 4 allows one point if the applicant/recipient has a very high level of disruptive behaviors ("wandering, verbally abusive, socially inappropriate behavior").

[123] CAT, p. 20. The "Limited Assistance" self-performance code of 2 is defined in the CAT as the recipient being "highly involved" in the activity, but receiving either "physical help in guided maneuvering of limbs, or other non-weight-bearing assistance" three or more times per week, or "weight bearing assistance one or two times" per week; a support code of 2 refers to receiving a "one-person physical assist."

[124] As to locomotion, while Mr. G. is mostly able to propel his wheelchair on his own, he needs physical assistance at least once or twice each day to push the chair because he gets stuck or has difficulty moving over certain surfaces. J. testimony; E. testimony; Ex. 23 at 437-438 (MDS data sheets for locomotion, showing 8 instances of "complete dependence" on staff for locomotion between 1/12/23 and 2/6/23). As for the ADL of toileting, the testimony of Mr. G.'s care team credibly established that he requires hands-on assistance with hygiene every time he defecates, as well as occasional non-weightbearing assistance transferring on/off the toilet. J. testimony; Ex. 23 at 439-440 (MDS data sheets for toileting, showing 10 instances of either "extensive assistance" or "complete dependence" on staff for toileting between 1/12/23 and 2/7/23). Mr. G. also requires weight bearing support for transfers, although the record is silent as to how frequently he uses such support.

[125] D. testimony.

which CNAs are not trained and which both doctors testified was critical in Mr. G.'s case.[126] Likewise, nursing staff monitor Mr. G.'s mental health and behavioral symptoms, watching for signs of distress and providing an array of interventions – including but not limited to administration of PRN medication – to address concerns as they arise.

The evidence similarly supports that nursing staff not only closely monitor Mr. G.'s water intake, but also engage with, redirect, and reeducate him to enforce his critically necessary water restrictions. It is this latter aspect of his needs that implicates ongoing care beyond simply "limiting his water intake."[127]

The evidence establishes that the nurses overseeing Mr. G.'s care are engaged in "the observation, assessment, and treatment" of his conditions on an ongoing basis. They use their skilled nursing judgment to make recommendations about needed modifications to his care plan.[128] Both of his medical providers – Dr. N. in particular – testified credibly to their reliance on the nurses' observations and judgment in ensuring Mr. G.'s health and safety. In short, the evidence supports the conclusion that Mr. G. meets the standard for intermediate care as set out in the Division's regulation.

IV. Conclusion

The evidence at hearing established that Mr. G. remains eligible for nursing facility care services. Accordingly, the Division's determination finding him ineligible is reversed.

DATED: October 23, 2023.

Signed
Daniel R. Phelps II
Project Coordinator, Department of Health
Final decisionmaker by Delegation of the
Commissioner of Health

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

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126 E. testimony; *see* 12 AAC 44.835, .845., and .847.
127 *Compare* D. testimony *with* J. testimony, E. testimony.
128 J. testimony; N. testimony.