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

In the Matter of	)	
	)	
K. X.	)	OAH No. 24-0848-MDS
	)	

FINAL DECISION

I. Introduction

Mr. K. X. applied for Medicaid Home and Community-Based Waiver, also known as Alaskans Living Independently Waiver, (ALI Waiver) benefits that would allow him to live in an assisted living home. His application was denied because the Division of Senior and Disability Services (Division) determined that he did not require a nursing facility level of care following an assessment by Suzan Kubitz, as well as review of his medical records, screening and application.

Mr. X., through his guardian L. O., and his attorney, Casey Willits of Alaska Legal Services Corp., requested a *de novo* hearing[1] to challenge the denial of his application. The hearing was held telephonically on Friday, February 14, 2025, beginning at 10:00 a.m. and continuing, with only short breaks, until 4:45 p.m. Ms. Willits represented Mr. X. and presented testimony from the following witnesses: C. Q., M.D., Mr. X.' physician; Ms. M. N., Mr. X.' care coordinator; Ms. B. P., Mr. X.' occupational therapist; Ms. N. T., Mr. X.' speech therapist; Ms. Abigail Kietzman, Providence nursing manager, Ms. D. V., manager of the assisted living home where Mr. X. resides; and L. O., Mr. X.' guardian and elder brother.
Assistant Attorney General Paul Peterson represented the Division, and presented testimony from Suzan Kubitz, R.N., nurse assessor for the Division, and Scott Chow, R.N., from the Division. The exhibits filed by the parties were admitted without objection and the record remained open to receive post-hearing briefing.

A proposed decision was issued on March 5, 2025, and a proposal for action was filed by Mr. X.' attorney on March 18, 2025 challenging the application of the date of decision as the determinative date in this case. Upon thorough review of the proposed decision and the record, the Commissioner's delegee finds that the proposed decision reached an incorrect

[1] 7 AAC 49.170.

conclusion regarding Mr. X.' eligibility for a skilled or intermediate nursing Level of Care (LOC).

Based largely on the results of the assessment and CAT by Ms. Kubitz, the Division concluded on November 19, 2024 that Mr. X. does not qualify for Waiver benefits.[2] As originally stated, the central issue is whether or not, based on the evidence provided in hearing, Mr. X.' CAT assessment was appropriately scored. The Division does not dispute that Mr. X. suffers from serious disabilities; however, even with increased scores based on evidence provided in hearing, it contends that Mr. X. is not eligible for Waiver services. On the other hand, Mr. X. contends that his ongoing therapy before and recommendations for care after discharge, difficult behavior, and his cognitive deficits combined with his ADL scores was sufficient to establish eligibility.

After reviewing the evidence, Mr. X.'s requirement for skilled therapies is sufficient to meet the LOC standard under the ALI Waiver program. At the time the CAT was performed, he should have been given a score of 3 on NF1 of the CAT instead of 0, based on the compelling evidence available to the assessor. Accordingly, the Division's denial of Mr. X.' application for ALI Waiver is REVERSED.

II. Facts

A. Overview of ALI Waiver Eligibility

The Alaskans Living Independently Waiver program is an Alaska Medicaid program for older or physically disabled adults requiring "a level of care provided in a nursing facility."[3] The program pays for services that allow an eligible applicant to stay in his or her home, or a home-like setting such as an assisted living facility, rather than move into an intermediate or skilled nursing facility.[4] Whether an applicant requires a "nursing facility level of care" is determined in part by an assessment documented through the "Consumer Assessment Tool" (CAT).[5] The CAT records an applicant's needs for professional nursing services, special treatments and therapies, cognitive impairment and behavioral problems, and the level of assistance the applicant requires for "activities of daily living" (ADLs), including specific categories:

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[2] Ex. D. Mr. Peterson represented that Mr. X. had been found eligible for General Relief, but what that he did not provide any information as to what that would mean in terms of placement in an assisted living facility. Mr. Peterson's representation is not relevant to the outcome of this case.

[3] 7 AAC 130.205(c).

[4] 7 AAC 130.215.

[5] 7 AAC 130.215(4).

bed mobility (how a person moves to and from lying position, turns side to side, and positions body while in bed);

transfers (how a person moves between surfaces – to and from bed, chair, wheelchair, and standing position);

locomotion (how a person moves between a location in his or her room and other areas on the same floor. If the person is in a wheelchair, then the person's self-sufficiency is assessed once in a chair);

eating (how a person eats and drinks regardless of skill);

toileting (how a person transfers on and off the toilet, adjusts clothing, and cleanses);

personal hygiene (how a person maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum); and

bathing (how a person takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower, exclude washing of back and hair).[6]

These ADLs are scored based on the amount of assistance an applicant requires to perform each activity. The applicant receives a two-part score consisting of a self-performance code on ability to perform the activity, and a support code reflecting the degree of assistance required to do so. The self-performance codes vary slightly for bathing, but generally these codes include:

0. INDEPENDENT - No help or oversight - or - Help/oversight provided only 1-2 times during last 7 days.
1. SUPERVISION - Oversight, encouragement or cueing provided 3+ times during last 7 days - or -Supervision plus non-weight-bearing physical assistance provided only 1 or 2 times during last 7 days.
2. LIMITED ASSISTANCE - Person highly involved in activity; received physical help in guided maneuvering of limbs, or other non-weight bearing assistance 3+ times - or - Limited assistance (as just described) plus weight-bearing 1 or 2 times during last 7 days.
3. EXTENSIVE ASSISTANCE - While person performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times: Weight-bearing support and/or Full staff/caregiver performance during part (but not all) of last 7 days.
4. TOTAL DEPENDENCE - Full staff/caregiver performance of activity during ENTIRE 7 days.

[6] Ex. E, pgs. 8-11.

5. CUEING - Spoken instruction or physical guidance which serves as a signal to do an activity are required 7 days a week. Cueing is typically used when caring for individuals who are cognitively impaired.[7]

The support codes are based on the greatest amount of support provided over each 24-hour period during the last seven days and range from 0 (no set up or physical help required) to 3 (physical assist from two or more people required). A separate code 5 is for cueing when required seven days a week.[8]

Each of the areas assessed in the CAT contribute to a final numerical score used to determine if the applicant meets the threshold for Waiver eligibility, a "nursing facility" (NF) level of care. To be eligible, an applicant's total score at section NF1 or NF7 of the CAT must be 3 or higher. This can be achieved in different ways. For example, an applicant requiring ongoing professional nursing services such as special therapies (occupational, physical, and speech) five to seven days a week would receive a qualifying score of 3 at NF1. Similarly, an applicant requiring specialized treatments, such as radiation or chemotherapy, five days a week could receive a score of 3 between NF1 and NF2. And a person requiring extensive physical assistance or who is completely dependent on another person (self-performance code of 3 or 4) in three or more of the five specified ADLs would receive a NF7 score of 3.[9] An applicant can also receive points towards eligibility through combinations of nursing services, ongoing special therapies, substantially impaired cognition, difficult behaviors, and needs for physical assistance with ADLs.

B. Factual background

Mr. X. is a 36-year-old man who formerly lived in Village A, a village of less than 200 people on the north shore of Lake A. According to his elder brother's testimony, Mr. X. quit his job at the water treatment plant and planned to move to Anchorage after fishing a season, with the intention of then getting a job on the North Slope. Before that plan was complete, he was involved in a near-fatal ATV accident, and flown from Village B to Providence Hospital in Anchorage, where he was admitted June 17, 2024, with a traumatic brain injury, broken ribs, fractured shoulder and arm, and other serious injuries. He was not discharged until October 25, 2024, when he was admitted to the assisted living facility where he currently resides.

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7 Ex. E, pg. 8.
8 *Id.*
9 Ex. E, pg. 34.

While he was in the hospital, his elder brother, L. O., and sister were appointed co-guardians and conservators of Mr. X..[10] Faced with imminent discharge from Providence, Mr. X.' guardians applied for ALI Waiver benefits on September 26, 2024.[11] On October 24, 2024, Ms. Kubitz conducted a video assessment on behalf of the Division at Providence Hospital. Mr. X.' brother was not physically present, although he participated telephonically; but Mr. X.' care coordinator, Ms. N., was physically present. Also present was a member of the hospital staff, identified as E.. Mr. X. was discharged from the hospital on October 25, 2024, to the care of Assisted Living A.[12]

Mr. X. was discharged with the following diagnoses: traumatic brain injury (with traumatic encephalopathy, bilateral hemorrhagic contusions, left subarachnoid hemorrhage); right humerus fracture (requiring plate and screws), chest trauma with rib fractures, and intraventricular hemorrhage. His medications included Divalproex (used to treat seizure disorders and mental conditions such as manic phase of bipolar disorder); Olanzapine (an atypical antipsychotic used to treat schizophrenia or bipolar disorder); Depakote (also used to prevent migraines or to treat manic episodes related to bipolar disorder); Propranolol (a beta blocker used to treat high blood pressure, angina, irregular heartbeat, tremors and migraines); tamsulosin, (an alpha blocker to treat symptoms of benign prostatic hyperplasia), and amantadine (an NMDA antagonist used to treat Parkinson's or dyskinesia (sudden uncontrolled movements). This last drug was discontinued by Dr. Q. at the November 18, 2024, appointment.[13]

III. Discussion

A. Burden of proof

Mr. X. is the applicant for waiver benefits, so he has the burden of proving by a preponderance of the evidence that he is eligible for Waiver benefits.[14] The parties can meet their burden of proof by producing any evidence upon which reasonable people might rely on in the conduct of serious affairs,[15] including such sources as written reports of firsthand evaluations of the patient or sworn testimony of witnesses who have had contact with the applicant. The

10 Ex. C.
11 Ex. G, pg. 3.
12 Ex. 7.
13 Ex. 6, pg. 2.
14 7 AAC 49.135.
15 2 AAC 64.290(a)(1).

relevant date for purposes of assessing the state of the facts is, in general, the date of the agency's decision under review.[16]

B. The Consumer Assessment Tool (CAT) scoring was flawed and does not support the Division's determination.

A person is eligible for an ALI Waiver if he or she accumulates enough points in the Consumer Assessment Tool (CAT) to establish the need for a nursing facility (NF) level of care**.** The CAT prepared by Ms. Kubitz (Ex. E) was done October 24, 2024, the day before Mr. X.' planned departure from the hospital. The CAT notes that Mr. X. had Occupational Therapy twice weekly,[17] but did not note provision of Speech Therapy and Physical Therapy, both provided while Mr. X. was hospitalized and prescribed to be continued following discharge.[18] It did not score *any* skilled therapies in Sections NF-1 or NF-2.[19]

The original September 25, 2024 plan of care by F. G., Occupational Therapist (OT), shows Mr. X. was receiving Occupational Therapy in the hospital, and her notes from October 25, 2024 (the day of discharge) recommend continued Occupational Therapy three times per week.[20] A September 13, 2024 Physical Therapy Screening Note indicates that he was to continue with physical therapy, but to decrease from daily to twice a week,[21] and a October 17, 2024 Physical Therapy Treatment Note indicates that he was to receive continuing outpatient physical therapy twice a week.[22] Mr. X.' physician noted in her November 18, 2024 post-discharge appointment that he was "still working with PT/OT/SLP from providence."[23] In addition, after discharge, skilled nursing visits for assessment, care and education were provided by Providence Home Health.[24] Despite the provision of these therapies, *before and to continue after discharge*, he was scored at 0 days per week for 0 therapies in Ms. Kubitz's CAT.[25]

Regulation 7 AAC 130.207(a)(1)(B) requires submission of an application for Medicaid Waiver services with "relevant supporting documents." While "relevant supporting documents"

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16 *See* 7 AAC 49.170, *In re T.C.*, OAH No. 13-0204-MDS (Comm'r of Health & Soc. Serv. 2013); *see also*, *In re L O-Q,* OAH No. 13-1418-MDS, n.32 (Comm'r of Health & Soc. Serv. 2014).

17 Ex. E, pg. 4.

18 Ex. G, pg. 13; Ex. 1, pg. 292-293 (recommending outpatient PT 2 times per week; Ex. 1, pg. 306 (documenting Speech Language Pathology treatment 4 times per week and recommending continuance).

19 Ex. E, pg. 7.

20 Ex. G, pg. 22.

21 Ex. G, pg. 45.

22 Ex. G, pg. 135.

23 Ex. 6, pg. 1.

24 Ex. 2, pg. 30.

25 Ex. E, pg. 7.

is not defined, 7 AAC 130.211(b)(2)(A) and (B) require the applicant's care coordinator to provide an application that contains "relevant and contemporaneous documentation" that "addresses each medical and functional condition" that indicates the applicant's need for Waiver services. Here, the evidence, in particular, the testimony of Ms. M. N. regarding her uploading of documents to Harmony at the time of the assessment, and their inclusion in the Division's exhibits, indicates that the Division did have records contemporaneous with the actual assessment that Mr. X. required at least five days of skilled therapy at the time of the assessment and that the recommendation of those licensed therapists was that they continue for *at least* five days per week after discharge. Based on this contemporaneous documentation, the assessor should have scored NF1 as a 3 instead of a 0.

A careful review of the hearing record reveals that Mr. X. provided compelling evidence contradicting the Division's determination that he did not meet the skilled or intermediate nursing Level of Care, based on the CAT. The physical therapy screening note dated September 13, 2024, prepared by physical therapy assistant, V. L. C., documents that Mr. X. was "at OP PT level" and recommended a reduced therapy frequency of twice per week.[26] Subsequently, the physical therapy treatment note dated October 17, 2024, by V. L. C., confirmed the continued need for therapy twice per week and further indicated that Mr. X. "currently requires continuous (24/7) assistance for community reintegration due to deficits in memory and cognition."[27] In addition, the occupational therapy treatment note filed on September 25, 2024, by occupational therapist F. L. G. recommended occupational therapy three times per week.[28]

The documentary evidence that physical therapy, occupational therapy, and speech-language therapy was needed after discharge was supported by testimony from C. Q., M.D., Mr. X.' primary physician; B. P., Mr. X.' occupational therapist, and N. T., Mr. X.' speech language pathology therapist. They confirmed that Mr. X. required and was provided ongoing therapy after discharge. No testimony was presented by the therapists, either from Providence Hospital or Providence Home Health, as to the reason he was

[26] Ex. G, pg. 45.
[27] *Id*, pg. 135.
[28] *Id*., pg. 22.

not provided the recommended number of days[29]. The records provide compelling evidence that Mr. X. required a mixture of physical, occupational, and speech therapies no less than five times per week through September and October of 2024. The evidence provided does not counter the recommendations of the discharging specialists and physician regarding Mr. X.' *required* skilled therapies. And, as the following review of the testimony presented indicates, there was no evidence that Mr. X.' condition had materially improved following discharge from Providence Hospital.

C. Dr. Q.'s testimony.

Dr. Q. testified that when she saw Mr. X. for a post-discharge appointment November 18, 2024, he had remote memory, but he was unable to recall matters they discussed at the beginning of the appointment. He was unable to give information about his current functional limitations, although he was able to describe his past capacities. He struggled with orientation to time and had a flat affect. He was working with home visit physical therapy and occupational therapy, and speech therapy, and she recommended that these continue.

Dr. Q. testified she referred him to Fuller Diagnostics for neurodiagnostic testing due to his traumatic brain injury, but later learned that practice no longer accepted Medicaid patients, so he "fell off their queue." She testified that she still referred him for such testing, but that takes months get an appointment if the patient is on Medicaid. However, she did arrange a MoCA (Montreal Cognitive Assessment) for him. MoCA is a screening test for early dementia or mild cognitive dysfunction. Dr. Q. testified that the behavioral health consultant who performed the test the day before her testimony reported that Mr. X. scored a 12 out of 30, which indicated severe impairment. She testified that Mr. X. even made words up in the word recall portion of the test. She continued to recommend physical, occupational and speech therapies through the TBI program at Provider A and he had agreed to this at his last appointment. The TBI outpatient therapy program combined physical therapy, occupational therapy, and speech therapy provided by licensed therapists.[30]

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[29] Ms. P. did not explain why she over-rode the recommendation of Mr. X.'s prior occupational therapist for therapy two days per week and reduced her visits to one day a week. The plan by U. H., PT, was for visits once a week, but did not explain why the prior recommendation was not followed. Ex. 2, pg. 55.

[30] *See*, *Baxter v. Sullivan,* 923 F.2d 1391, 1396 (9th Cir.1991) (where the treating doctor's opinion is not contradicted by another doctor, it may be rejected only for "clear and convincing" reasons); *Embrey v. Bowen,* 849 F.2d 418, 422 (9th Cir.1988) ("clear and convincing" reasons are required to reject the treating doctor's ultimate conclusions).

D. Ms. N.'s testimony

Ms. M. N. testified that she has been a registered nurse for more than 25 years. She has a B.S. in Nursing, a Master's degree in Health Care Administration and certifications in Health Care Risk Management, Health Care Quality, and Patient Safety. She is Mr. X.'s care coordinator. She testified that, although she sees Mr. X. at least once a month, he does not remember her or who she is. He does not remember tasks that she gives him. She reported that Mr. X. eloped several times from the assisted living facility where he lives, and she has had to speak with the police or the home employees on these occasions. Mr. X. would say he needed to go to his aunt's house or to work, even at two in the morning. She testified that while he was in the hospital, he had to be kept in the hospital, though he walked the halls, as he would try to leave.

Ms. N. was present for the CAT and noted some things that were out of the ordinary. She noted anomalies in how the memory recall or cognition test was administered, for example. Ms. N. testified that she had submitted Occupational Therapy and Physical Therapy notes through Harmony on October 24, 2024, and that, from the Harmony record, the notes were read at 10:06 a.m. that day. Ms. N. testified Mr. X. continued to receive therapy through Providence Home Health from a Physical Therapist, Occupational Therapist, and a Speech Therapist. Ms. N. did not speak to the number of visits per week the therapists provided.

E. Ms. P.'s testimony

Ms. B. P. testified that she is a licensed, registered Occupational Therapist with Providence Home Health. She did her initial evaluation on October 30, 2024.[31] At that time, he had dizziness, double vision, and back pain, so she felt that he needed supervision because he did not have sufficient insight and orientation for safety. He was able to physically ambulate indoors with reminders and dress himself with cueing and supervision. For example, he would put on a shirt inside out or backwards or need reminders to where his shirt was. On multiple occasions he would not realize his pants were not pulled up but were low on his thighs. He would wander away during appointments while Ms. P. was talking. He was not oriented to date or time. She worked with Mr. X. for a few months, seeing him once a

[31] Ex.2, pgs. 36-37.

week[32], but on January 7, 2025, when she discharged him into outpatient services; he had not met all his goals at that time.

Ms. P. testified during that entire time she felt Mr. X. lacked insight and capacity to do things like cooking or managing his medications, so those were left entirely with the assisted living facility. During one of Ms. P.'s visits, he said he wanted to live on his own, and he would go to work, like he was right then (wearing shorts and a t-shirt in winter).
She testified there was no linear, logical thinking on his plan to go to work. She testified he was at high risk of putting himself in dangerous situations due to his lack of insight.

F. Ms. T.'s testimony

Ms. T. is a speech pathologist with Providence Home Health Care who saw Mr. X. twice weekly following his discharge from Providence Hospital.[33] She testified she is a licensed speech and hearing therapist. The focus of her therapy was on his cognition. He was discharged to outpatient speech therapy January 5, 2025.

Ms. T. stated that, as of her last visit, Mr. X.' condition had reached a plateau; but, in view of his continuing cognitive difficulties he required constant supervision. He relied heavily on cueing and redirection. She felt his attention span was about three minutes. He was not able to independently use planners or other methods to help with his short-term memory deficits. He had very poor insight into his planning or problem-solving skill deficits. He could not manage his appointments, would not be able to shop for himself, or maintain orientation to dates. He would not initiate any independent activities of daily living, like take his medication, without cueing.

G. Ms. Keitzman's testimony

Ms. Keitzman, the Nurse Manager at Providence Hospital on the unit where Mr. X. received care, testified credibly to Mr. X.'s behavior at Providence Hospital during the course of his stay. She described in vivid detail how, shuffling with his head down, Mr. X. would walk ten miles a day in the hospital, even going to areas where he was not allowed, such as the Children's ICU. He did not have any particular aim or purpose in his wandering, just a restlessness that compelled him to move. She described how he wandered into other patient's rooms, frightening them, and how staff would have to walk with him, trying to guide him back to

[32] Ex. Ex. 2, pg. 37.
[33] Ex. 2, pg. 59.

his room. A special sign was put on his door to help him recognize which room was his. He was initially aggressive, even almost breaking one person's nose, so that staff needed to be accompanied when entering his room and a security guard was posted outside his room. The hospital security guards were alerted to his wandering, to keep him from leaving the hospital.

H. Ms. V.'s testimony

Ms. V. is the administrator of Assisted Living Home A, the assisted living home where Mr. X. resides. She testified that Mr. X. walks almost constantly, up and down the two halls, when he is awake, unless he can be distracted to sit at the table or watch a television show. She testified that alarms had to be put on the doors and the doors locked to keep him indoors. She testified that the one time she took him to Walmart, he disappeared, and she had to get the Walmart staff to help find him – he was found outside in the parking lot walking away. She testified that he will refuse to take medication, and need to be persuaded, or call staff names and get angry with them when kept from leaving or otherwise asked to do something. He is not allowed in the kitchen because of fear he will forget the stove is on and put his hand on it. He does not sleep all night, but he will get up saying he has to go to work, or leave for another reason.

I. Insufficiency of evidence supporting CAT score

No explanation was offered by Ms. Suzan Kubitz, R.N., nurse assessor for the Division, as to why the evidence contained in these records was not determinative as she prepared the CAT; her focus appeared to be on Mr. X.' physical abilities as demonstrated in her video call with him.

Mr. X. received only one day of physical therapy per week, one day of occupational therapy per week, and two days of speech therapy from Providence Home Health, effectively half what was recommended at the time of discharge. At the time of denial, then, he was receiving four days of skilled therapies, less than the recommended five or more days per week. Nonetheless, there was, at the time, contemporaneous, uncontradicted documentation of the need for skilled therapies endorsed by his physician sufficient to be scored as "3" in NF1. Because the denial of Waiver services was based on the CAT which omitted the treatment notes for continuing skilled therapies on discharge, the denial is based on flawed evidence.[34]

[34] The record and testimony presented demonstrated other significant errors in the CAT. For example, based on her interview with Mr. X., Ms. Kubitz scored Section C-1a, Short-term Memory as "Memory OK." This assessment was contradicted by every other witness who has interacted with Mr. X., all describing how he had

Turning to the impact of the reduced services provided by Providence Home Health, there is no medical evidence showing why the reduction occurred. 7 AAC 130.215 does not require that an individual be actively receiving required therapies to meet a level of care; rather, it directs the Department to determine whether the applicant *requires* the level of care provided in a skilled nursing facility (under 7 AAC 140.515) or an intermediate care facility (under 7 AAC 140.510) based on the results of the Department's CAT, adopted by reference in 7 AAC 160.900, or an interim level-of-care review[35]. Thus, while at the time of the determination Mr. X. was not actually receiving the care he required, the CAT, if properly scored, would have supported a qualifying level of care.[36]

difficulty recalling information given even a short time ago, including Dr. Q., Ms. Keitzman, Ms. T., Ms. N., Ms. V., and Ms. P.. Ms. Kubitz's explanation for scoring his short-term memory as OK in section C1 is not convincing, particularly in light of a MoCA score of 12 out of 30 reported by Dr. Q. and Dr. Q.'s experience of Mr. X. *the day before the division's determination.* In this respect, C1a should have reflected "1 memory problems". At Section C-3, Ms. Kubitz scored Mr. X. as "1-Modified independence-Some Difficult in New Situations Only." However, both Ms. P. and Ms. T. testified to the difficulty Mr. X. faced making decisions in a rational or logical manner at the most mundane level over several months. For instance, he stated that he wanted to go to work, in winter, by walking there in shorts and t-shirt, and that he would "hang out with the homeless guys" who were his friends. He cannot be trusted to be in the kitchen because he forgets if the stove is on. He needs to be cued constantly to wash, shower, dress appropriately, remain focused in therapy, do simple tasks. He is subject to guardianship and his brother testified that if he returned to the village, he would wander into the forest and never be found. His score at C-3 should be 2, moderately impaired-decisions poor, cues/supervision required. There was also substantial testimony supporting an increase in scores in section C-4B(2) to a 3. Similar, concerning errors are reflected in the CAT scoring of behaviors. Ms. Kubitz scored Mr. X. as a 0 for wandering. Yet, Ms. Krietzman testified to Mr. X.'s persistent, aimless, prolonged wandering around the hospital. She testified that staff had to accompany him as he would go into places like the Children's ICU regardless of the signs, or into other patient's rooms. Ms. N., Mr. O., and Ms. V. testified to the danger he presents to himself through his wandering. Mr. X. repeatedly left the home wandering around town, to be brought back by the police. He would walk until he was tired and stop, sitting wherever he was, even in the road.

He would get up in the middle of the night, and try to leave, saying it was time to go to work, or that he had to leave to go visit an aunt or a friend. Mr. X.'s aimless persistent wandering continues in the home, and he is only prevented from departing by the alarmed, locked doors or by being distracted by a television show he wants to watch. Ms. V. also testified he is also frequently verbally abusive to staff and will resist taking his medications.

[35] 7 AAC 130.215; Ex. B, pgs. 5-6.

[36] *See, In the Matter of L. O-Q*, OAH No. 13-1418-MDS, n.32 (Comm'r of Health & Soc. Serv. 2014) (noting the Commissioner's level decision is that the Division is to use the applicant/recipient's condition as of the date of the decisional document and not the date of the assessment, for determining eligibility for benefits). *But see*, 7 AAC 49.170, excepting cases in which "the applicant or recipient has requested de novo review." In this case, the applicant requested de novo review. It is noted that Mr. X. is not shown to have refused Providence Home Health therapies, and that he has agreed to participate in the Provider A's recent TBI therapy program.

IV. Conclusion

In summary, Mr. X. had the burden of proof in this case to demonstrate by a preponderance of the evidence his eligibility for Alaska Medicaid Waiver benefits. Mr. X. met this burden. Based on the evidence presented at hearing and available to the Division at the time of its determination—particularly the records identified in Exhibit G—and due to the failure of the Division to produce sufficient contrary evidence, the Commissioner's delegee finds that the assessor incorrectly scored NF1 in Mr. X.' CAT and that this should have been scored 3. The Commissioner's delegee further finds that there was convincing evidence in the record that Mr. X. requires a sufficient nursing facility level of care to qualify for ALI waiver services. Therefore, the determination of the Division that Mr. X. is ineligible for such services is REVERSED.

Dated: April 7, 2025

SIGNED
Daniel R. Phelps II
Process Improvement Manager
Final Decision Maker by Delegation from the
Commissioner of Health

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Assistant Attorney General Paul Peterson represented the Division, and presented testimony from Suzan Kubitz, R.N., nurse assessor for the Division, and Scott Chow, R.N., from the Division. The exhibits filed by the parties were admitted without objection and the record remained open to receive post-hearing briefing.

Based largely on the results of the assessment and CAT by Ms. Kubitz, the Division concluded November 19, 2024 that Mr. X. does not qualify for Waiver benefits.[2] The

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[2] Ex. D. Mr. Peterson represented that Mr. X. had been found eligible for General Relief, but what that he did not provide any information as to what that would mean in terms of placement in an assisted living facility. Mr. Peterson's representation is not relevant to the outcome of this case.

central issue here is whether or not, based on the evidence provided in hearing, Mr. X.' CAT assessment was appropriately scored. The Division does not dispute that Mr. X. suffers from serious disabilities; however, even with increased scores based on evidence provided in hearing, it contends that Mr. X. is not eligible for Waiver services. On the other hand, Mr. X. contends that his ongoing therapy before and after discharge, difficult behavior, and his cognitive deficits combined with his ADL scores is sufficient to establish eligibility.

After reviewing the evidence carefully, Mr. X.' cognitive, behavioral, and functional limitations (which the Division conceded are serious) are still not sufficient to meet the standard under the ALI Waiver program because, at the time he was denied, he was not *receiving* sufficient therapies (although they were recommended) to score a 3 on NF1 of the CAT, and he did not accumulate enough points on other portions of the CAT to qualify under NF7. Accordingly, the Division's denial of Mr. X.' application for ALI Waiver is AFFIRMED.

II. Facts

A. Overview of ALI Waiver Eligibility

The Alaskans Living Independently Waiver program is an Alaska Medicaid program for older or physically disabled adults requiring "a level of care provided in a nursing facility."[3] The program pays for services that allow an eligible applicant to stay in his or her home, or a home-like setting such as an assisted living facility, rather than move into an intermediate or skilled nursing facility.[4] Whether an applicant requires a "nursing facility level of care" is determined in part by an assessment documented through the "Consumer Assessment Tool" (CAT).[5] This form records an applicant's needs for professional nursing services, special treatments and therapies, cognitive impairment and behavioral problems, and the level of assistance the applicant requires for "activities of daily living" (ADLs), including specific categories:

> bed mobility (how a person moves to and from lying position, turns side to side, and positions body while in bed);
>
> transfers (how a person moves between surfaces – to and from bed, chair, wheelchair, and standing position);

[3] 7 AAC
[4] 7 AAC
[5] 7 AAC

locomotion (how a person moves between a location in his or her room and other areas on the same floor. If the person is in a wheelchair, then the person's self-sufficiency is assessed once in a chair);

eating (how a person eats and drinks regardless of skill);

toileting (how a person transfers on and off the toilet, adjusts clothing, and cleanses);

personal hygiene (how a person maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum); and

bathing (how a person takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower, exclude washing of back and hair).[6]

These ADLs are scored based on the amount of assistance an applicant requires to perform each activity. The applicant receives a two-part score consisting of a self-performance code on ability to perform the activity, and a support code reflecting the degree of assistance required to do so. The self-performance codes vary slightly for bathing, but generally these codes include

0. INDEPENDENT - No help or oversight - or - Help/oversight provided only 1-2 times during last 7 days.
1. SUPERVISION - Oversight, encouragement or cueing provided 3+ times during last 7 days - or -Supervision plus non-weight-bearing physical assistance provided only 1 or 2 times during last 7 days.
2. LIMITED ASSISTANCE - Person highly involved in activity; received physical help in guided maneuvering of limbs, or other non-weight bearing assistance 3+ times - or - Limited assistance (as just described) plus weight-bearing 1 or 2 times during last 7 days.
3. EXTENSIVE ASSISTANCE - While person performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times: Weight-bearing support and/or Full staff/caregiver performance during part (but not all) of last 7 days.
4. TOTAL DEPENDENCE - Full staff/caregiver performance of activity during ENTIRE 7 days.
5. CUEING - Spoken instruction or physical guidance which serves as a signal to do an activity are required 7 days a week. Cueing is typically used when caring for individuals who are cognitively impaired.[7]

[6] Ex. E, pgs. 8-11.
[7] Ex. E, pg. 8.

The support codes are based on the greatest amount of support provided over each 24-hour period during the last seven days and range from 0 (no set up or physical help required) to 3 (physical assist from two or more people required). A separate code 5 is for cueing when required seven days a week.[8]

Each of the areas assessed in the CAT contribute to a final numerical score used to determine if the applicant meets the threshold for Waiver eligibility, a "nursing facility" (NF) level of care. To be eligible, an applicant's total score at section NF1 or NF7 of the CAT must be 3 or higher. This can be achieved in different ways. For example, an applicant requiring ongoing professional nursing services such as special therapies (occupational, physical, and speech) five to seven days a week would receive a qualifying score of 3 at NF1. Similarly, an applicant requiring specialized treatments, such as radiation or chemotherapy, five days a week could receive a score of 3 between NF1 and NF2. And a person requiring extensive physical assistance or who is completely dependent on another person (self-performance code of 3 or 4) in three or more of the five specified ADLs would receive a NF7 score of 3.[9] An applicant can also receive points towards eligibility through combinations of nursing services, ongoing special therapies, substantially impaired cognition, difficult behaviors, and needs for physical assistance with ADLs.

B. Factual background

Mr. X. is a 36-year-old man who formerly lived in Village A, a village of less than 200 people on the north shore of Lake A. According to his elder brother's testimony, Mr. X. quit his job at the water treatment plant and planned to move to Anchorage after fishing a season, with the intention of then getting a job on the North Slope. Before that plan was complete, he was involved in a near-fatal ATV accident, and flown from Village B to Providence Hospital in Anchorage, where he was admitted June 17, 2024, with a traumatic brain injury, broken ribs, fractured shoulder and arm, and other serious injuries. He was not discharged until October 25, 2024, when he was admitted to the assisted living facility where he currently resides.

While he was in the hospital, his elder brother, L. O., and sister were appointed co-guardians and conservators of Mr. X..[10] Faced with imminent discharge from

[8] *Id.*
[9] Ex. E, pg. 34.
[10] Ex. C.

Providence, Mr. X.' guardians applied for ALI Waiver benefits on September 26, 2024.[11] On October 24, 2024, Ms. Kubitz conducted a video assessment on behalf of the Division at Providence Hospital. Mr. X.' brother was not physically present, although he participated telephonically; but Mr. X.' care coordinator, Ms. N., was physically present. Also present was a member of the hospital staff, identified as E.. Mr. X. was discharged from the hospital on October 25, 2024, to the care of Assisted Living A.[12]

Mr. X. was discharged with the following diagnoses: traumatic brain injury (with traumatic encephalopathy, bilateral hemorrhagic contusions, left subarachnoid hemorrhage); right humerus fracture (requiring plate and screws), chest trauma with rib fractures, and intraventricular hemorrhage. His medications included Divalproex (used to treat seizure disorders and mental conditions such as manic phase of bipolar disorder); Olanzapine (an atypical antipsychotic used to treat schizophrenia or bipolar disorder); Depakote (also used to prevent migraines or to treat manic episodes related to bipolar disorder); Propranolol (a beta blocker used to treat high blood pressure, angina, irregular heartbeat, tremors and migraines); tamsulosin, (an alpha blocker to treat symptoms of benign prostatic hyperplasia), and amantadine (an NMDA antagonist used to treat Parkinson's or dyskinesia (sudden uncontrolled movements). This last drug was discontinued by Dr. Q. at the November 18, 2024, appointment.[13]

III. Discussion

A. Burden of proof

Mr. X. is the applicant for waiver benefits, so he has the burden of proving by a preponderance of the evidence that he is eligible for Waiver benefits.[14] The parties can meet their burden of proof by producing any evidence upon which reasonable people might rely on in the conduct of serious affairs,[15] including such sources as written reports of firsthand evaluations of the patient or sworn testimony of witnesses who have had contact with the applicant. The relevant date for purposes of assessing the state of the facts is, in general, the date of the agency's decision under review.[16]

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11 Ex. G, pg. 3.
12 Ex. 7.
13 Ex. 6, pg. 2.
14 7 AAC 49.135.
15 2 AAC 64.290(a)(1).
16 *See* 7 AAC 49.170, *In re T.C.*, OAH No. 13-0204-MDS (Comm'r of Health & Soc. Serv. 2013).

B. The Consumer Assessment Tool (CAT) scoring

A person is eligible for an ALI Waiver if he or she accumulates enough points in the Consumer Assessment Tool (CAT) to establish the need for a nursing facility (NF) level of care**.** The CAT prepared by Ms. Kubitz (Ex. E) was done October 24, 2024, the day before Mr. X.' planned departure from the hospital. The CAT notes that Mr. X. had Occupational Therapy twice weekly,[17] but did not note provision of Speech Therapy and Physical Therapy, both provided while Mr. X. was hospitalized and prescribed to be continued following discharge.[18] It did not score *any* skilled therapies in Sections NF-1 or NF-2.[19]

The original September 25, 2024 plan of care by F. G., OT, shows he was receiving Occupational Therapy in the hospital, and her notes from October 25, 2024 (the day of discharge) recommend continued Occupational Therapy three times per week.[20] A September 13, 2024 Physical Therapy note indicates that he was to continue with physical therapy, but to decrease from daily to twice a week,[21] and on October 17, 2024, the physical therapist notes that he was to receive continuing outpatient physical therapy twice a week.[22] Mr. X.' physician noted in her November 18, 2024 post-discharge appointment that he was "still working with PT/OT/SLP from providence."[23] In addition, after discharge, skilled nursing visits for assessment, care and education were provided by Providence Home Health.[24] Despite the provision of these therapies, *before and after discharge*, he was scored at 0 days per week for 0 therapies in Ms. Kubitz's CAT.[25]

Regulation 7 AAC 130.207(a)(1)(B) requires submission of an application for Medicaid Waiver services with "relevant supporting documents." While "relevant supporting documents" is not defined, 7 AAC 130.211(b)(2)(A) and (B) require the applicant's care coordinator to provide an application that contains "relevant and contemporaneous documentation" that "addresses each medical and functional condition" that indicates the applicant's need for Waiver services. Here, the evidence, in particular, the testimony of Ms. M. N. regarding her

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17 Ex. E, pg. 4.
18 Ex. G, pg. 13; Ex. 1, pg. 292-293 (recommending outpatient PT 2 times per week; Ex. 1, pg. 306 (documenting Speech Language Pathology treatment 4 times per week and recommending continuance).
19 Ex. E, pg. 7.
20 Ex. G, pg. 22.
21 Ex. G, pg. 45.
22 Ex. G, pg. 135.
23 Ex. 6, pg. 1.
24 Ex. 2, pg. 30.
25 Ex. E, pg. 7.

uploading of documents to Harmony at the time of the assessment, and their inclusion in the Division's exhibits, indicates that the Division did have records contemporaneous with the actual assessment that Mr. X. was receiving more than five days of skilled therapy at the time of the assessment and that the recommendation of those licensed therapists was that they continue for *at least* five days per week after discharge. Based on this contemporaneous documentation, the assessor could have scored NF1 as a 3 instead of a 0.

The documentary evidence that physical therapy, occupational therapy, and speech-language therapy was needed after discharge was supported by testimony from C. Q., M.D., Mr. X.' primary physician; B. P., Mr. X.' occupational therapist, and N. T., Mr. X.' speech language pathology therapist. They all confirmed that Mr. X. required and was provided ongoing therapy after discharge. However, Ms. P. did not explain why she over-rode the recommendation of Mr. X.'s prior occupational therapist for therapy two days per week and reduced her visits to one day a week.

C. Dr. Q.'s testimony.

Dr. Q. testified that when she saw Mr. X. for a post-discharge appointment November 18, 2024, he had remote memory, but he was unable to recall matters they discussed at the beginning of the appointment. He was unable to give information about current his functional limitations, although he was able to describe his past capacities. He struggled with orientation to time and had a flat affect. He was working with home visit physical therapy and occupational therapy, and speech therapy, and she recommended that these continue.

Dr. Q. testified she referred him to Fuller Diagnostics for neurodiagnostic testing due to his traumatic brain injury, but later learned that practice no longer accepted Medicaid patients, so he "fell off their queue." She testified that she still referred him for such testing, but that takes months get an appointment if the patient is on Medicaid. However, she did arrange a MoCA (Montreal Cognitive Assessment) for him. MoCA is a screening test for early dementia or mild cognitive dysfunction. Dr. Q. testified that the behavioral health consultant who performed the test the day before her testimony reported that Mr. X. scored a 12 out of 30, which indicated severe impairment. She testified that Mr. X. even made words up in the word recall portion of the test. She continued to recommend physical, occupational and speech therapies through the TBI program at Provider A and he had agreed to this at his last appointment. The

TBI outpatient therapy program combined physical therapy, occupational therapy, and speech therapy provided by licensed therapists.

D. Ms. N.'s testimony

Ms. M. N. testified that she has been a registered nurse for more than 25 years. She has a B.S. in Nursing, a Master's degree in Health Care Administration and certifications in Health Care Risk Management, Health Care Quality, and Patient Safety. She is Mr. X.'s care coordinator. She testified that, although she sees Mr. X. at least once a month, he does not remember her or who she is. He does not remember tasks that she gives him. She reported that Mr. X. eloped several times from the assisted living facility where he lives, and she has had to speak with the police or the home employees on these occasions. Mr. X. would say he needed to go to his aunt's house or to work, even at two in the morning. She testified that while he was in the hospital, he had to be kept in the hospital, though he walked the halls, as he would try to leave.

Ms. N. was present for the CAT and noted some things that were out of the ordinary. She noted anomalies in how the memory recall or cognition test was administered, for example. Ms. N. testified that she had submitted Occupational Therapy and Physical Therapy notes through Harmony on October 24, 2024, and that, from the Harmony record, the notes were read at 10:06 a.m. that day. Ms. N. testified Mr. X. continued to receive therapy through Providence Home Health from a Physical Therapist,[26] Occupational Therapist, and a Speech Therapist. Ms. N. did not speak to the number of visits per week the therapists provided.

E. Ms. P.'s testimony

Ms. B. P. testified that she is a licensed, registered Occupational Therapist with Providence Home Health. She did her initial evaluation on October 30, 2024.[27] At that time, he had dizziness, double vision, and back pain, so she felt that he needed supervision because he did not have sufficient insight and orientation for safety. He was able to physically ambulate indoors with reminders and dress himself with cueing and supervision. For example, he would put on a shirt inside out or backwards or need reminders to where his shirt was. On multiple occasions he would not realize his pants were not pulled up but were low on his thighs. He would wander away during appointments while Ms. P. was talking. He was not

[26] Ex. 2, pg. 55. The plan by U. H., PT, was for visits once a week.
[27] Ex.2, pgs. 36-37.

oriented to date or time. She worked with Mr. X. for a few months, seeing him once a week[28], but on January 7, 2025, she discharged him into outpatient services; he had not met all his goals at that time.

Ms. P. testified that during the entire time she felt Mr. X. he lacked insight and capacity to do things like cooking or managing his medications, so those were left entirely with the assisted living facility. During one of Ms. P.'s visits, he said he wanted to live on his own, and he would go to work, like he was right then (wearing shorts and a t-shirt in winter). She testified there was no linear, logical thinking on his plan to go to work. She testified he was at high risk of putting himself in dangerous situations due to his lack of insight.

F. Ms. T.'s testimony

Ms. T. is a speech pathologist with Providence Home Health Care who saw Mr. X. twice weekly following his discharge from Providence Hospital.[29] She testified she is licensed speech and hearing therapist. The focus of her therapy was on his cognition. He was discharged to outpatient speech therapy January 5, 2025.

Ms. T. stated that, as of her last visit, Mr. X.' condition had reached a plateau; but, in view of his continuing cognitive difficulties he required constant supervision. He relied heavily on cueing and redirection. She felt his attention span was about three minutes. He was not able to independently use planners or other methods to help with his short-term memory deficits. He had very poor insight into his planning or problem-solving skill deficits. He could not manage his appointments, would not be able to shop for himself, or maintain orientation to dates. He would not initiate any independent activities of daily living, like take his medication, without cueing. Ms. T. also testified, without objection, that she received a phone call from the outpatient therapist (unnamed) who, she said, felt that he was not able to make further progress.

G. Ms. Keitzman's testimony

Ms. Keitzman, the Nurse Manager at Providence Hospital on the unit where Mr. X. received care, testified credibly to Mr. X.'s behavior at Providence Hospital during the course of his stay. She described in vivid detail how, shuffling with his head down, Mr. X. would walk ten miles a day in the hospital, even going to areas where he was not allowed, such

[28] Ex. Ex. 2, pg. 37.
[29] Ex. 2, pg. 59.

as the Children's ICU. He did not have any particular aim or purpose in his wandering, just a restlessness that compelled him to move. She described how he wandered into other patient's rooms, frightening them, and how staff would have to walk with him, trying to guide him back to his room. A special sign was put on his door to help him recognize which room was his. He was initially aggressive, even almost breaking one person's nose, so that staff needed to be accompanied when entering his room and a security guard was posted outside his room. The hospital security guards were alerted to his wandering, to keep him from leaving the hospital.

H. Ms. V.'s testimony

Ms. V. is the administrator of Assisted Living Home A, the assisted living home where Mr. X. resides. She testified that Mr. X. walks almost constantly, up and down the two halls, when he is awake, unless he can be distracted to sit at the table or watch a television show. She testified that alarms had to be put on the doors and the doors locked to keep him indoors. She testified that the one time she took him to Walmart, he disappeared and she had to get the Walmart staff to help find him – he was found outside in the parking lot walking away. She testified that he will refuse to take medication, and need to be persuaded, or call staff names and get angry with them when kept from leaving or otherwise asked to do something. He is not allowed in the kitchen because of fear he will forget the stove is on and put his hand on it. He does not sleep all night, but he will get up saying he has to go to work, or leave for another reason.

I. Sufficiency of evidence of skilled therapies to score NF1 as a qualifying 3 at denial

A close review of the records in evidence shows that, while in the hospital for the last weeks, Mr. X. received occupational therapy three days per week and physical therapy twice per week in addition to speech therapy four times per week. This totals nine days per week, sufficient to be scored "3" in NF1 and on that basis alone to be "found eligible for NF (Nursing Facility) level of care, and thus eligible for Waiver services. It is also noted that the recommendation for discharge care was for two days of occupational therapy and two days of physical therapy per week, plus speech therapy four days per week.

However, these recommendations were not followed. Mr. X. received only one day of physical therapy per week, one day of occupational therapy per week, and two days of speech therapy from Providence Home Health, effectively half what was recommended. At the time of denial, then, he was receiving four days of skilled therapies, less than the recommended five or

more days per week. Nonetheless, there was, at the time, contemporaneous documentation of the need for skilled therapies endorsed by his physician sufficient to be scored as "3" in NF1. On this basis alone, he should be determined eligible for Waiver services. However, because he was not, at the date of the decision, receiving the prescribed level of therapies, he is not eligible to receive a 3 in NF1.[30]

J. The evidence presented does not support a qualifying Nursing Facility score

The actual provision of occupational, physical, and speech therapy provided at the time of the decision to deny Mr. X.'s application is sufficient to score 1 in NF2. Although an NF2 "1" score does not render Mr. X. eligible, if Mr. X. could accumulate 2 more NF points through the CAT process, he could reach a qualifying total of 3. He attempted to show that a combination of needs for assistance in the "shaded areas" of Activities of Daily Living" (totaled in section E) and his cognitive deficits plus his behavior problems would be sufficient to award a score of "1" in NF3 and NF4. To score "1" in NF3, Mr. X. needed to show that all of the questions a through d were answered "yes;" similarly to score 1 in NF4, he needed to show that both questions a and b were answered "yes."

1. Cognition

Based on her interview with Mr. X., Ms. Kubitz scored Section C-1a, Short-term Memory as "Memory OK." This assessment was contradicted by every other witness who has interacted with Mr. X., all describing how he had difficulty recalling information given even a short time ago, including Dr. Q., Ms. Keitzman, Ms. T., Ms. N., Ms. V., and Ms. P.. Ms. Kubitz's explanation for scoring his short-term memory as OK in section C1 is not convincing, particularly in light of a MoCA score of 12 out of 30 reported by Dr. Q. and Dr. Q.'s experience of Mr. X. *the day before the decision.* In this respect, C1a should have reflected "1 memory problems".

At Section C-3, Ms. Kubitz scored Mr. X. as "1-Modified independence-Some Difficult in New Situations Only." However, both Ms. P. and Ms. T. testified to the difficulty Mr. X. faced making decisions in a rational or logical manner at the most

[30] *See, In the Matter of O-Q*, OAH No. 13-1418-MDS, n.34 (Comm'r of Health & Soc. Serv. 2014). It is noted that Mr. X. is not shown to have refused Providence Home Health therapies, and that he has agreed to participate in the Provider A's recent TBI therapy program. If he is documented as receiving more skilled therapies through that program, he could perhaps reapply for Waiver services on the basis of a material change in condition.

mundane level over several months. For instance, he stated that he wanted to go to work, in winter, by walking there in shorts and t-shirt, and that he would "hang out with the homeless guys" who were his friends. He cannot be trusted to be in the kitchen because he forgets if the stove is on. He needs to be cued constantly to wash, shower, dress appropriately, remain focused in therapy, do simple tasks. He is subject to guardianship and his brother testified that if he returned to the village, he would wander into the forest and never be found. His score at C-3 should be 2, moderately impaired-decisions poor, cues/supervision required.

Professional nursing assessment was provided at the time of the decision, but it was only at 2 days per week, and was not planned to continue monthly.[31] Section C-4A(4) requires nursing assessment 3 days per week; and C-4A(5) requires monthly assessment. Therefore, Section C-4 is scored 0 correctly. There was substantial testimony supporting an increase in scores in section C-4B(2) to a 3. However, this increase, with that at C-3, only raises the score to 9, which is insufficient to reach the 13 required by NF3(d). Therefore, while the subsidiary cognitive scores should be increased, the increase is not sufficient to result in a score of 1 at NF3, which requires an affirmative response to every sub-question.

2. Behaviors

Similarly, there was strong evidence that Mr. X. presents problem behaviors that merit higher scores in Section D than Ms. Kubitz gave him based on her video meeting at Providence Hospital. Ms. Krietzman testified to Mr. X.'s persistent, aimless, prolonged wandering around the hospital. She testified that staff had to accompany him as he would go into places like the Children's ICU regardless of the signs, or into other patient's rooms. Ms. N., Mr. O., and Ms. V. testified to the danger he presents to himself through his wandering. He repeatedly left the home wandering around town, to be brought back by the police. He would walk until he was tired and stop, sitting wherever he was, even in the road. He would get up in the middle of the night, and try to leave, saying it was time to go to work, or that he had to leave to go visit an aunt or a friend. His aimless persistent wandering continues in the home, and he is only prevented from departing by the alarmed, locked doors or by being distracted by a television show he wants to watch.

Ms. Kubitz scored Mr. X. as 0 in frequency and 0 in problem behavior for Wandering. The testimony of those who have observed him directly and for more than the short

[31] Ex. 2, pg. 30.

period of the video assessment is that he does this on a daily basis, and, while he can be diverted, the behavior itself cannot be easily altered. Therefore section D1(a) should be increased to a 3 in frequency and a 1 in the problem score. According to Ms. V. he is also frequently verbally abusive to staff and will resist taking his medications, but he can be persuaded to take the medication eventually.

Although Ms. Kubitz scored him as having no problem behaviors, it is clear that Mr. X. meets the "behavior impairment" threshold to have been scored in Section D2B (which Ms. Kubitz completed). In sleep patterns, she scored him as "unchanged from 'normal' for the consumer" despite the information that he regularly woke up and started wandering even in the hospital. There was testimony from those who had more opportunity to observe that he would wake in the middle of the night, or (from one observer, be asleep in the day); therefore, he should have a score of "1" at D2-B-1, instead of 0.

There was ample credible testimony to Mr. X.'s aimless wandering, and Ms. Kubitz did score him at a 3 in D2-B-2. However, she indicated "he does not have a history of getting lost" but, as Ms. N., Ms. Krietzman, and Ms. V. testified, he does have a history of getting lost, even in Providence, and having to be returned by police to the assisted living home. He also is taking significant psychotropic drugs, usually prescribed to address manic behavior in bipolar disorders. Therefore D2-B-2 should be scored as a 4.

D2-B-3, Behavioral Demands on Others, should be scored above 0 because his habit of wandering does limit his living arrangement. He must live in a facility where he is not at risk of wandering away in the middle of the night, for example. This section is properly scored at a 1 or 2. D2-B-4 should be scored at 2 based on the testimony of Ms. V., who has had months of observation of Mr. X. being verbally abusive to staff, and observed his relentless walking through the halls of the facility. Section 5, Awareness of Needs/Judgment should be increased to a 2 based on his constant need for cueing.

Taken together, Mr. X.'s scores in the Behavior screening tool (D2-B) total 10 or 11. Unfortunately, this is not high enough to meet the required score in NF4 which is 14. Therefore, he cannot reach a qualifying score through a 1 in NF4. His total nursing score in NF5 (NF1+NF2+NF3+NF4) is 1.

3. Need for physical assistance is insufficient to qualify

Because his score in NF 5 is only 1, Mr. X. needs to accumulate at least 2 "shaded" ADL's that were coded with a 2, 3, or 4 in self-performance AND required physical assist in support (i.e., support coded as 2 or 3). This the testimony did not support. While Ms. V. testified that Mr. X. requires physical support to rise from a sitting position when he complained about back pain, this was not substantiated as Mr. X. requiring limited weight-bearing assistance[32] and at least one person to provide physical assistance on a regular basis in moving between locations (locomotion) or transfers (chair to standing). And, while he requires supervision and extensive cueing, and he receives some assistance, showering, Ms. Kubitz and Mr. Chow's testimony suggested that, with a long-handled brush, he could wash his own feet, reducing his need for assistance to supervision. The need for at least one person to provide physical help moving his limbs on a regular basis, or weight-bearing assistance, in two or more shaded ADL's was not established by the testimony of Ms. V. or the other witnesses. And, unfortunately, his need for extensive cueing and supervision does not provide the score needed in NF-5. Therefore, the total nursing facility score (NF17) is 1, and Mr. X. does not at this time qualify for waiver services.

IV. Conclusion

In summary, Mr. X. had the burden of proof in this case to demonstrate his eligibility for Alaska Medicaid Waiver benefits. Mr. X.'s need for skilled therapies, if they had been provided at the recommended levels after leaving the hospital, would have been sufficient to qualify him for such benefits. However, the preponderance of the evidence is that he does not, despite severe cognitive and behavioral impairments, meet the threshold for benefits based on those impairments. In addition, he did not establish sufficient evidence of the need for qualifying physical assistance in the scored ADLs. Therefore, the denial of Mr. X.'s application for Medicaid Waiver benefits is AFFIRMED.

Dated: February 28, 2025

SIGNED
Kristin S Knudsen
Administrative Law Judge

[32] *See, In re K T-Q*, OAH Case No. 13-0271-MDS, p.4 (Comm'r of Dep't of Health & Soc. Serv. June 21, 2013) ("Weight bearing assistance should be interpreted as supporting more than a minimal amount of weight. It does not require that the assistant bear most of the recipient's weight, but instead that the recipient could not perform the task without the weight bearing assistance.").