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STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
OFFICE OF HEARINGS AND APPEALS

In the Matter of)
)
[redacted],) OHA Case No. 10-FH-2297
)
Claimant.) Div. Case No. [redacted]

FAIR HEARING DECISION

STATEMENT OF THE CASE

Ms. [redacted] (Claimant) applied for Medicaid benefits[1] under the Home and Community Based Waiver Older Alaskans Program (hereinafter "Waiver Program"). Claimant was assessed for eligibility for the Waiver Program on June 2, 2010. (Exs. E & F) On June 9, 2010, Claimant was given written notice that her application was denied based on a determination that she did not need skilled nursing or structured rehabilitation that would be provided in a skilled nursing facility, or intermediate care characterized by the need for licensed nursing services provided in an intermediate care facility. (Ex. D)

Claimant did not immediately request review of the denial of her application but instead filed a Motion for Temporary Restraining Order in Superior Court as case number 3AN-10-09467.[2]

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[1] The record does not indicate the date of Claimant's initial application. The parties stipulated Claimant applied after February 1, 2010, probably in June 2010.

[2] The Order on the Motion for Temporary Restraining Order contains two case numbers: in the Caption it is case 3AN-10-[redacted] and in the footer on each page of the order the case number is 3AN-10-[redacted]. (Ex. G) For purposes of this decision, the discrepancy is immaterial.

It appears from reading the Order that Claimant requested the Court restrain the State from discharging her from Alaska Psychiatric Institute (API) until it had been finally determined whether she financially qualified for Medicaid benefits and/or was determined eligible for the Home and Community Based Older Alaskans Waiver Program. Financial eligibility for Medicaid benefits was not part of the hearing in this case (10-FH-2297). However, the Division of Senior and Disabilities Services did suggest Claimant is financially eligible for Medicaid. State's Reply to Claimant's Initial Post-Hearing Brief of October 22, 2010 at 2: ("… she now is Medicaid eligible which means she has access to other Medicaid services and to general relief assistance for assisted living home placement.")

Claimant was denied a temporary restraining order but the parties resolved several issues by agreement.[3] (Ex. G, pp. 2-3)

After the Order denying Claimant a temporary restraining order was issued, the parties further agreed Claimant should be assessed a second time, based on the same application for Medicaid benefits which had caused the June 2, 2010 assessment. (Nurse's testimony) Claimant's second assessment took place on August 24, 2010 and was completed by the Division's registered nurse (Nurse). (Ex. I; Ex. J) On September 2, 2010, the Division of Senior and Disabilities Services (Division) sent the Claimant notice her application was denied based on the second eligibility determination. (Ex. H) On August 13, 2010, Claimant requested a fair hearing contesting the denial. (Ex. C)

This Office has jurisdiction pursuant to 7 AAC 49.010.

The hearing was held on September 16, 2010. The Division was represented at the hearing by Ms. , Esq., Assistant Attorney General, who appeared in person. Ms , Esq., Assistant Attorney General, also represented the Division in the case but did not participate at the hearing. Ms. , (Nurse) a registered nurse employed with the Division, appeared in person and testified on the Division's behalf. Ms. , a registered nurse employed with the Division, appeared in person on the Division's behalf, but did not testify. Mr. , Esq., Attorney with the Disability Law Center, represented Claimant. Ms. , Claimant's daughter, (daughter) appeared in person and testified on behalf of Claimant. Claimant did not appear.

All exhibits offered were admitted and the hearing was closed on September 16, 2010. The record was left open for post-hearing briefing and closed on October 22, 2010.

DECISION SUMMARY

The parties did not dispute that Claimant is physically able to carry out all the activities of daily living without need for assistance. The parties also did not dispute that Claimant's needs are manifested behaviorally and arise from her chronic condition of dementia. Claimant needs to be protected from wandering and the effects of confusion: Claimant needs cueing and to take medication to control her dementia.

The Division determined Claimant's needs were insufficient to meet the nursing level of care to make her eligible for the Older Alaskans Waiver Program because she did not need a nursing level of care.

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[3] Claimant sought review of the denial of her application by the Superior Court, asking for a temporary restraining order preventing the discharge of Claimant from Alaska Psychiatric Institute. (*See*, Case No. 3AN-10- , *v. State*). On August , 2010, the Superior Court denied issuing a temporary restraining order, holding, in part, that Claimant "has administrative remedies available that undercut the need for a TRO." (, Id. at 3.) The Superior Court further wrote in its denial order "The parties accepted the Court's suggestion that [Claimant] file a motion for summary judgment on her ADA claim while reapplying for Medicaid and seeking a hearing on the Waiver Program application." *Id.*

Claimant was assessed using the Consumer Assessment Tool and the *Manual* factors and found not to require a skilled nursing facility or an intermediate level nursing facility level of care.

Claimant did not prove by a preponderance of the evidence that she required a nursing facility level of care. The Division therefore correctly denied Claimant's application for the Home and Community Based Older Alaskans Waiver Program.

ISSUE

Claimant argues that although she is not physically impaired, her dementia causes her to need the level of care (skilled nursing or intermediate level of care nursing) provided by the Waiver program. The Department agrees Claimant does not need skilled nursing or an intermediate level of care due to physical needs, but disagrees that Claimant's dementia qualifies her for the level of care provided by a skilled nursing facility or intermediate care facility.[4]

The issue in this case is whether the Senior and Disabilities Services Division was correct when, on September 2, 2010, it denied Claimant's application for Medicaid Home and Community Based Older Alaskans Waiver services because it determined Claimant did not require a nursing facility level of care as of August 24, 2010.

FINDINGS OF FACT

The following facts have been established by a preponderance of the evidence:

1. The Claimant is an 81 year old woman (date of birth [redacted], 1929) diagnosed with dementia. (Ex. I-1; Daughter's testimony) At the time of her August 24, 2010 assessment, she was living at the Alaska Psychiatric Institute (API). (Nurse's testimony)

2. Claimant was placed into the care of API in May 2010 after her living arrangements progressed from living independently in her own home to being taken to a hospital emergency room after wandering away from an assisted living residence. (Daughter's testimony) This progression of living arrangements took place approximately between the time of fall 2009 to and including September 16, 2010, the date of the fair hearing. (Daughter's testimony)

3. Claimant applied for Medicaid assistance under the Home and Community Based Waiver Program for Older Alaskans (Waiver Program) and was assessed for this Waiver Program eligibility twice. (Ex. E; Ex. I) The first assessment, of June 2, 2010, resulted in a determination that Claimant was not eligible for the Waiver Program.[5] (Ex. D) Claimant was re-assessed on August 24, 2010 by

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[4] The Department also argues Claimant medically qualifies for personal care assistance provided by a program other than the Home and Community Based Older Alaskans Waiver Program. This issue is not properly a part of this decision: *see* footnote 7.

[5] The assessment of June 2, 2010 was not addressed at the hearing, and the issues in this case have been narrowed to the denial of eligibility based on the assessment of August 24, 2010.

registered nurse [redacted], who also determined Claimant was not eligible for the Waiver Program. (Ex. H) Specifically, Claimant was denied participation in the Waiver Program because:

> she did "not need skilled nursing or structured rehabilitation ordered by and under the direction of a physician that would be provided in a skilled nursing facility" and did "not need intermediate care which is characterized by the need for licensed nursing services ordered by and under the direction of a physician that would be provided in an intermediate care facility." (Ex. H-3)

4. The Nurse completed a Consumer Assessment Tool (CAT) when she assessed Claimant on August 24, 2010. (Ex. I)

5. The CAT assessment determined that, as of August 24, 2010:

   a. Claimant experiences cognition problems such that she could not draw a clock or recall 3 items in five minutes but had no problems with functionality. (Ex. I-4) Claimant was physically capable and 100% independent with activities of daily living but needed cueing/supervision with eating, locomotion and brushing her hair and teeth at times. (Ex. I-4)

   b. Claimant did not require any therapies provided by a qualified therapist (physical therapy, speech therapy, occupational therapy or respiratory therapy). (Ex. I-5)

   c. Claimant had no prescriptions requiring hands-on assistance from a Personal Care Assistant (PCA). (Ex. I-5)

   d. Claimant was able to get up abruptly from a lying position in bed without assistance (bed mobility). (Ex. I-6) She received a self-performance code of 0 (independent) and a support code of 0 (none required) in this category. (Ex. I-6)

   e. Claimant had no difficulty transferring between surfaces (eg. from bed to chair or to standing.) (Ex. I-6) She received a self-performance code of 0 (independent) and a support code of 0 (none required) in this category. (Ex. I-6)

   f. Claimant had no difficulty with locomotion and did not need help to walk independently, but was scored as needing cueing on both the self-performance and support scores. (Ex. I-7) She received a self-performance code of 5 (cueing assistance required) and a support code of 5 (cueing assistance required) in this category. (Ex. I-7)

   g. Claimant was able to dress herself with no assistance (Ex. I-8). She received a self-performance code of 0 (no assistance required) and a support code of 0 (no assistance required) in this category (Ex. I-8).

   h. Claimant did not require any hands on assistance with eating but needed cueing. (Ex. I-9). She received a self-performance code of 5 (cueing assistance required) and a support code of 5 (cueing assistance required) in this category. (ExI-9)

i. Claimant required no physical assistance with transferring to or from the toilet and no physical assistance with personal hygiene when using the toilet but needed cueing. (Ex. I-9) She received a self-performance code of 5 (cueing assistance required) and a support code of 5 (cueing assistance required) in this category. (Ex. I-9)

j. Claimant performed her own personal care/hygiene but needed cueing. (Ex. I-10) She received a self-performance code of 5 (cueing assistance required) and a support code of 5 (cueing assistance required) in this category. (Ex. I-10)

k. Claimant generally required no physical assistance with bathing; she had good range of motion and was functionally strong but needed cueing. (Ex. I-11). She received a self-performance code of 5 (cueing assistance required) and a support code of 5 (cueing assistance required) in this category. (Ex. I-11)

l. Claimant required help with her medications twice a day each day. (Ex. I-12)

m. Claimant did not require any professional nursing services. (Ex. I-13, I-14)

n. Claimant required no special treatments or therapies. (Ex. I-15)

o. Claimant experienced memory problems in both short-term and long-term memory and was given a code of 1. (Ex I-16) Claimant was assessed as severely impaired in cognitive skills for daily decision-making and given a code of 3 (severely impaired). (Ex. I-16)

p. Claimant did exhibit the problem behavior of wandering. (Ex. I-17) Claimant was assessed as wandering daily and given a frequency code of 3 (moving with no rational purpose, seemingly oblivious to needs or safety) and a problem behavior code of 1 (behavior not easily altered). (Ex. I-17) More specifically, Claimant was assessed as:

1. An assessment code of 3 in the category of Behavior "[w]andering within the facility or residence. May wander outside, health and safety may be jeopardized. Does not have a history of getting lost and is not combative about returning." (Ex. I-18)

2. An assessment code of 1 in the category of "Behavioral Demands on Others: "Having attitudes, habits or emotional states which limit the individual's type of living arrangement and companions." (Ex. I-18)

3. An assessment code of 2 in the category of "Awareness of Needs/Judgment: "Frequently … has difficulty understanding those needs that must be met but will cooperate when given direction or explanation." (Ex. I-18)

Significantly, Claimant was assessed as not requiring professional nursing assessment, observation and management to manage the behavior problem. (Ex. I-17)

q. Claimant had no problems with hearing, speaking, or seeing, other than the need to wear glasses or contact lenses to correct her vision. (Ex. I-23) Claimant was assessed to sometimes have problems making herself understood and understanding others. (Ex. I-23)

r. Claimant had no nutritional problems. (Ex. I-24). The Claimant had no incontinence problems. (Ex. I-24) The Claimant had no balance problems. (Ex. I-24)

s. Claimant had no skin problems, pressure ulcers or problems with her feet. (Ex. I-25). Claimant wore dentures or had a removable bridge. (Ex. I-25)

t. Claimant was assessed as having only one type of mood problem (self-deprecation) which was scored as "easily altered." (Ex. I-26).

u. Claimant needed help with many of her Instrumental Activities of Daily Living (IADLs) (Ex. I-27). Specifically, she was totally dependent on meal preparation, light housework, routine housework, laundry and grocery shopping. (Ex. I-27) She also needed transportation. (Ex. I-27) Claimant was able to use the telephone with some assistance. (Ex. I-27)

Claimant's score on the Consumer Assessment Tool was a "1". (Ex. I-30) This was the result of totaling the scores Claimant received on the assessed items: Claimant was scored a "1" because she had cognitive impairment. (Ex. I, pp. 16, 30) Nurse [redacted] found Claimant did not qualify for the Waiver Program because she did not need a nursing facility level of care. (Ex. I-31; Nurse's testimony)

6. On September 2, 2010, [redacted], R.N., reviewed the August 24, 2010 assessment and evaluated Claimant according to the *Manual* factors. (Ex. J-1) The Nurse determined Claimant did not meet any skilled level of care factors.[6] (Ex. J-1) The nurse determined Claimant met only the intermediate level of care factor described as "[a]ssistance with ADLs, including maintenance of Foley catheters, ostomies, supervision of special diets, and proper skin care of incontinent patients," which the nurse wrote Claimant met because she needed "[s]upervision with locomotion, eating, toileting, personal hygiene and bathing." (Ex. J-2)

7. At the September 16, 2010 hearing, Claimant's daughter testified, in part, as follows:

a. Whereas previously Claimant had been living independently, the decline of her mental functioning has resulted in her requiring increased supervision: Until fall 2009, Claimant lived alone in her Anchorage home. In October 2009, Claimant began staying overnight at a home where she was cared for by others who could orient her.

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[6] Exhibit J consists of a two page checklist which shows the result of applying the *Manual* factors. (Nurse's testimony) Before February 2010, when the Division assessed an applicant for eligibility for the Waiver Program, the Division was <u>required</u> by 7 AAC 43.190 to consider factors identified in the *Manual for Prior Authorization of Long Term Care Services (Manual)*. In February 2010, regulations applicable to the Waiver Program were repealed and reenacted <u>without requiring</u> consideration of the *Manual* factors. 7 AAC 140.505. The Division's Older Alaskans Waiver Program Policy and Procedure Manual does require consideration of the *Manual* factors as part of the eligibility determination. (Ex. 31, p. 17) The Division did consider them as part of its assessment of Claimant. (Ex. J) *See*, Analysis.

Claimant needed orienting as to where she resided, the time of day when she woke and how to deal with thoughts people were stealing from her. Claimant was physically fully functional.

b. In February 2010, Claimant returned to her own home and had a live-in caregiver, who was absent part of the day. This arrangement terminated on April 13, 2010, when the caregiver reported Claimant had tried to attack her and the police took Claimant to a hospital emergency room.

c. Claimant was discharged from the hospital to her daughter's home temporarily. About April 16, 2010, Claimant moved to an assisted living home with other residents present in the home. About five (5) days later, Claimant walked out the door and down the street. The staff at the residence could not leave the other residents to get Claimant, so the owner got Claimant and took her to a hospital emergency room, psychiatric section.

d. The following day, the hospital discharged Claimant to another assisted living facility. After a week there, on May 1, 2010, Claimant walked from her residence near Fireweed Lane to the Sears Mall, where she had a clerk use Claimant's cell phone to call her daughter to come and pick her up. Claimant's daughter called the police who again took Claimant to a hospital emergency room.

e. Claimant was discharged from the hospital to Alaska Psychiatric Institute on May 2, 2010 where she remained at the time of the hearing on September 16, 2010. Initially, Claimant was to be there for a three day evaluation. Claimant's daughter believes Claimant has someone with her all the time at API because Claimant has wandered into other patient's rooms and "basically caused problems." Claimant's daughter believes Claimant needs someone to "keep an eye on her" during the day but would be all right to be alone at night. Claimant needs the kind of supervision which would prevent her from wandering away from the facility where she is housed.

f. Prior to being admitted to API on May 2, 2010, Claimant was not under regular doctor's care. In late 2009, Claimant tried Aricept but abandoned the medication due to side effects. Claimant did not take medication for her dementia prior to May 2, 2010, the date of her arrival at API, although she may have received medication during her second admission to the hospital emergency room. Claimant is resistant to medication and Claimant's daughter believes a proper environment can obviate Claimant's need for medication for her dementia.

g. Since Claimant has been on medication at API, Claimant appears calmer and mostly stable. It is the only time she has been consistently taking medications and has been monitored to ensure she takes them. Claimant also seems very depressed and is spending a lot of time in her room and in her bed, which is not customary for Claimant, who generally is physically active. This seems to be because Claimant doesn't like being at API. She has been prescribed anti-depressants.

h. Claimant is fully functional with daily physical activities. Claimant dislikes showering and therefore needs cueing to bathe, but can take care of herself after being reminded to bathe.

8. The Alaska Psychiatric Institute (API) records provided evidence as follows:

a. On May 2, 2010, Claimant arrived at Alaska Psychiatric Institute (API). (Ex. 1, p. 1) By August 2010, API had a discharge plan (Plan) for Claimant that would have her transfer to an assisted living facility that provides a higher level of supervision than the one(s) where she previously resided. (Ex. G-1)

b. While at API between May 2, 2010 and September 16, 2010, Claimant engaged in behaviors which initially did not include aggression but did include wandering. As time progressed, Claimant complained about lack of family contact, manifested aggressive behavior in relation to her perception of being "locked up" and wanting to leave, and anger and confusion about her circumstances. (Ex. 1)

c. Instances of behavioral events Claimant manifested while at API are recorded in Exhibits 6-29. The recorded behavioral events memorialize mood changes, agitation, confusion, wandering and need for cueing. Claimant's near fall on June 5, 2010, after being bumped or startled by a staff member, is memorialized in Exhibit 21-2. On August 11, 2010, Claimant was caught by a staff member as she slowly fell to her right side. (Ex. 28-2)

d. On May 29, 2010, Claimant's behavior was recorded as appropriate, cheerful, and self-caring. (Ex. 9) On May 25, 2010, the record states, in part: "[p]lacement is the main reason being kept in Hospital against her wish" and "has had a good day and has had no unpredictable behavior…" and "early this evening, she be[redacted]e upset and agitated about staff not telling her what to do, angry about staff doing 15 minutes check when in her room, accusing staff of stealing her things and calling staff burglars." (Ex. 14) *See also,* Exhibits 15-2 and 22.

e. Claimant is easily re-oriented and re-directed when confused. (*See* Exs. 6-1; 8-1; 14-2; 15; 20-2; 27-2) Claimant's primary stressors are her belief her family has abandoned her, her failing memory, and the fact that she cannot leave where she is staying. (Exs. 7-1; 10-1; 13) Claimant is compliant with taking medication, even if on occasion she at first objects. (Exs. 8-2; 9-1; 12; 23)

f. In July 2010 and continuing to August 2010, Claimant complained she did not believe she was in API only until a place for her to live could be found, complained she wanted to go home, and also expressed a desire to die. (Exs. 23; 24; 25-3; 26; 27-1)

9. [redacted], R.N., (Nurse) reviewed Claimant's June 2, 2010 assessment and spoke with the nurse who assessed Claimant's condition on June 2, 2010. On August 24, 2010, the Nurse interviewed and assessed Claimant at API, reviewed "not all" of Claimant's API records, and spoke

with API staff involved with Claimant. (Ex. I; Nurse's testimony) On September 2, 2010, the Nurse evaluated Claimant applying the *Manual* factors checklist to Claimant's need for skilled level of care and intermediate level of care. (Ex. J) On September 9, 2010 the Nurse notified by Claimant by letter she had been determined not eligible for the Waiver Program. (Nurse's testimony) Ms. [redacted] (Nurse) testified, in part, as follows:

a. The Nurse outlined some of the steps of her evaluation of Claimant in the September 2, 2010 letter that notified Claimant of the denial of Alaska Waiver Payment for Choice Waiver Services. (Ex. H) Also, the Nurse assessed Claimant before she talked with the staff at API and spoke briefly with Claimant's doctor.

b. The Nurse also spoke "on and off," during her assessment, with Claimant's assigned staff "one-on-one", a mental health technician named [redacted]. [redacted] stated he believed the "one-on-one" assignment to Claimant was not needed and did not know why a one-on-one was considered needed. The Nurse also spoke with [redacted], Discharge Planner, and [redacted], Nurse Manager of API's Denali Unit. The Nurse Manager stated a one-on-one was needed because Claimant was at risk of falling and recalled in May 2010 Claimant had bumped into another API client, been startled, and fell back. The Discharge Planner stated a one-on-one was needed due to Claimant's confusion. Nurse also spoke with [redacted], API Social Worker, who worked on the history portion of Claimant's discharge plan. Mr. [redacted] believed a one-on-one staff was needed for Claimant's safety because of her wandering.

c. The Nurse observed Claimant to walk physically independent of a "one-on-one" staff and not needing physical assistance.

d. The Nurse reviewed Claimant's API records and read that Claimant had been administered anti-psychotic (Zyprexa and Seroquel) medication once daily to treat dementia and calm Claimant. The administration of prescription medications Zyprexa and Seroquel to a patient may be done independently by the patient or may be administered by others in many types of settings. Claimant did not receive other anti-psychotic medications at the time of the assessment on August 24, 2010; however, Claimant received other medicines, specifically, a hyper-tensive medication, aspirin, and an anti-diarrhea medication. Claimant is totally cooperative with taking her medications according to Claimant's caregivers at API.

e. The staff told the Nurse that Claimant was not combative or aggressive and that Claimant's behavior was mostly wandering and confusion. During the assessment, Claimant told the Nurse she (Claimant) "really liked going outside." Claimant's earlier aggressive or combative behavior noted in the API records was no longer present at the August 24, 2010 assessment date.

f. The Nurse reviewed the assessment and considered the *Manual* factors in addition to the CAT assessment. (Ex. J) The Nurse found Claimant qualified for the Intermediate Level of Care Factor "Assistance with ADLs… because Claimant needed "[s]upervision with locomotion, eating, toileting, personal hygiene and bathing." (Ex.

J-2) The Nurse determined Claimant did not need specialized or skilled nursing services but that Claimant did need cueing and supervision of her wandering. The Nurse determined Claimant cooperated in taking medication with cueing. The Nurse made the eligibility determination that Claimant was not eligible for the Older Alaskans Waiver Program. (Ex. H)

PRINCIPLES OF LAW

A party who is seeking a change in the status quo has the burden of proof by a preponderance of the evidence. *State, Alcohol Beverage Control Board v. Decker*, 700 P.2d 483, 485 (Alaska 1985); *Amerada Hess Pipeline v. Alaska Public Utilities Comm'n,* 711 P.2d 1170, n. 14 at 1179 (Alaska 1986). "Where one has the burden of proving asserted facts by a preponderance of the evidence, he must induce a belief in the minds of the [triers of fact] that the asserted facts are probably true." *Robinson v. Municipality of Anchorage,* 69 P.3d 489, 495 (Alaska 2003).

An adult 65 years old or older, who requires "a level of care provided in a nursing facility…" is entitled to receive Medicaid Home and Community Based Waiver services. 7 AAC 130.205(d)(1)(D) and (d)(2)(iii). [7]

Regulation 7 AAC 130.205(b)(2)[8] states, in relevant part, that an older adult is not eligible for Medicaid home and community based waiver services unless the individual requires the nursing

[7] There are other eligibility criteria, however, those are not at issue in this case. *See* 7 AAC 130.205(a) and (b).

[8] Regulation 7 AAC 130.205(a) provides for payment under Medicaid for home and community based waiver services provided to an individual. Subsection (b) of 7 AAC 130.205 prohibits payment for these services to an individual whose needs may be provided for entirely by services under other Medicaid programs, specifically those provided in 7 AAC 105-160. Therefore, if Claimant's needs can be met by Medicaid programs other than the Home and Community Based Waiver Services, she is ineligible for the Older Alaskans Waiver Program. This is mandatory by operation of regulation 7 AAC 130.205(b) and is irrespective of the outcome of the CAT assessment and *Manual* factor eligibility determination made in this case. Otherwise stated, if Claimant's needs can be met by a Medicaid program other than the Waiver Program, then she is not eligible for the Waiver Program.

However, Claimant's request for a fair hearing challenged the denial of her eligibility for the Home and Community Based Older Alaskans Waiver Program and the parties did not address her medical eligibility for other Medicaid programs.

The State argued its post-hearing brief that Claimant was eligible for other Medicaid programs that Claimant's needs would be met by an assisted living home with non-nursing staff present. State's Closing Brief of October 13, 2010 at 11. It argued Claimant is barred from the Waiver Program by operation of 7 AAC 130.205(b)(2) because her needs can be met by "regular Medicaid services." *Id.* at 13. It argued that assisted living care is appropriate for Claimant and can meet all her needs. State's Reply to Claimant's Initial Post-Hearing Brief of October 22, 2010 at 2-4.

These arguments are not addressed in this decision because they include issues not within the scope of the September 2, 2010 "Denial of Alaska Waiver Payment for Choice Waiver Services" letter notifying Claimant her application had been denied. Claimant has the procedural due process right to know what issues she must address at a hearing prior to the hearing. Claimant was not notified of these issues until the State argued them in its Post-Hearing Brief.

facility level of care as determined under 7 AAC 130.230(b) and under 7 AAC 140.505 - 7 AAC 140.515. If an individual's needs can be met entirely by other Medicaid services (provided under 7 AAC 105 - 7 AAC 160), the individual is not eligible for home and community based services provided under 7 AAC 130.200 - 130.319. 7 AAC 130.205(b)(2).

Regulation 7 AAC 130.230(b) requires a level of care assessment to determine eligibility.

> …to determine if the applicant meets the level of care required under 7 AAC 130.205(d)(2), the department will authorized the care coordinator to prepare a complete assessment of the applicant's physical, emotional, and cognitive functioning and need for care and services.

Regulation 7 AAC 130.230(b)(2), which applies to adults 65 years of age and older, requires the department to:

> (A) …determine whether the applicant requires skilled care under 7 AAC 140.515 or intermediate care under 7 AAC 140.510; and
>
> (B) [the] level of care determination under (A) … must incorporate the results of the department's *Consumer Assessment Tool (CAT)*, adopted by reference in 7 AAC 160.900. (Emphasis supplied.)

Regulations 7 AAC 140.505 - 140.515 set out factors the department must consider when determining the appropriate level of care for an individual seeking Waiver services.

Regulation 7 AAC 140.505 requires the department to consider:[9]

> (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.

Regulation 7 AAC 140.515, titled "Skilled nursing facility services,"[10] provides that skilled level of care is:[11]

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[9] Regulation 7 AAC 140.505 is similar to regulation 7 AAC 43.190, which was repealed on February 1, 2010. In 7 AAC 43.190, the division was required to "make a level-of-care evaluation in accordance with the guidelines established in the Criteria for Placement section of the *Manual for Prior Authorization of Long Term Care Services*, adopted by reference in that regulation. The revised regulation, found at 7 AAC 140.505, does not require consideration of the Criteria, which had become named the "*Manual* factors." In this case, the Nurse assessing Claimant incorporated the "*Manual*" factors as part of her assessment. (*See,* Ex. J) The Nurse testified about Exhibit J at the hearing: she referred to the "*Manual."*

[10] The acronym SNF refers to "skilled nursing facility."

[11] Subsection (c) of 7 AAC 140.515 pertains to structural rehabilitation services (in the nature of physical therapy) which are not at issue in this case. (*See,* Ex. B, pp. 20-21).

> (a) (1) needed to treat an unstable condition; (2) ordered by and under the direction of a physician; and (3) provided directly by or under the supervision of qualified technical or professional personnel, who are authorized by state law to provide that service and who are on the premises at the time service is rendered; technical or professional personnel include a registered nurse, a licensed practical nurse, a licensed physical therapist, a licensed physical therapy assistant, a licensed occupational therapist, a certified occupational therapy assistant, a licensed speech-language pathologist, a registered speech-language pathologist assistant, and an audiologist.
>
> (b) Skilled nursing services are 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.

Regulation 7 AAC 140.510, titled "Intermediate care facility services,"[12] provides that intermediate care services are:

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

Regulation 7 AAC 130.230(b)(2)(B) requires the department to incorporate results of the Consumer Assessment Tool (CAT) into the level of care determination made for an older adult applying for Medicaid Waiver Program services.[13] The Consumer Assessment Tool (CAT) is used to determine whether an applicant requires either skilled care or intermediate care. The nurse assessing an individual uses the CAT to determine the applicant's needs in respect to a nursing level of care on a number of physical and mental aspects. This assessment includes consideration of applicant's need for professional nursing services, for therapy provided by a qualified therapist, for special treatments

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[12] The acronym ICF refers to intermediate care facility.

[13] The Consumer Assessment Tool (CAT) is adopted by reference by regulation 7 AAC 160.900(d)(6) and is specifically included in the eligibility determination for Medicaid Home and Community Based Waiver services by 7 AAC 130.230(b)(2)(B). The CAT also is applied to determine if an applicant is eligible for other Medicaid based services and provides a comprehensive picture of an applicant's medical needs.

(eg. dialysis, chemotherapy), and whether an applicant experiences impaired cognition, or problem behaviors, among other things. (Ex. I)

The nurse assessing an applicant applies the CAT to the previous 7 days and considers other health, medical or functional needs since the last assessment and/or the previous 12 months. (Ex. I-2) The CAT includes comprehensive information about an applicant and includes evaluation of the types of therapies and frequency they are needed which have been prescribed for an applicant. (Ex. I, pp. 5; 21-25; 28-30) The CAT includes consideration of the medications an applicant has been prescribed and the need for professional nursing services, including special treatments for chronic conditions or medical procedures. (Ex. I, pp. 12-15; 21) An applicant's cognition, decision making, and behavior and mood are assessed. (Ex. I, pp. 16-18; 26) The nurse assesses an applicant's independence as to instrumental activities of daily living (IADL's) by rating the applicant's participation as to self-performance and support needed in such activities as meal preparation, managing finances, housework, grocery shopping, laundry, and ability to transport himself or herself to appointments and activities. (Ex. I-27)

The nurse assessing an applicant applies the CAT to determine an applicant's condition and needs in respect to activities of daily living (ADL), which include bed mobility (moving within a bed), transfers (e.g., moving from the bed to a chair, or a couch, etc.), locomotion (walking), dressing, eating, personal hygiene (e.g., hair and tooth care), bathing, and toilet use, which includes transferring on and off the toilet. (Ex. I, pp. 6-11; Ex. I-19, 20) The assessing nurse assigns a numerical score for many assessed items: the applicant is scored on self-performance and on the degree of support needed. (Ex. I, pp. 6-11)

The self-performance codes rate how capable a person is of performing a particular activity:

0 Independent, no help/oversight, or help/oversight provided two times or less during the last seven days.
1 Supervision, which consists of encouragement/oversight/cueing provided three or more times during the last seven days or supervision plus non-weight bearing physical assistance provided one or two times during the last seven days.
2 Limited Assistance, which consists of non-weight bearing physical assistance three or more times during the last seven days, or limited assistance plus weight bearing assistance one or two times during the last seven days.
3 Extensive Assistance, which consists of weight bearing support three or more times during the past seven days, or the caregiver provides complete performance of the activity during a portion of the past seven days.
4 Total Dependence, which consists of the caregiver performing the activity for the applicant during the entire previous seven day period.
5 Cueing, which is spoken instruction or physical guidance for a particular activity required seven days per week.
8 Activity did not occur during the previous seven days.

The support codes rate the amount of assistance a person receives for each activity:

0 None.

1	Setup assistance only.
2	One person physical assistance.
3	Physical assistance from two or more people.
5	Cueing required seven days per week.
8	Activity did not occur during the previous seven days.

(e.g., Ex. I-6)

The scores of each assessment are then processed to determine whether the applicant meets the nursing level of care required for eligibility for Waiver services. If the total nursing and activities of daily living score is 3 or greater, the applicant is determined to appear medically eligible for the nursing facility level of care, as required by 7 AAC 130.205(d)(2). (Ex. I-30)

Review of Assessment[14]

As a policy and procedure, each assessment must be reviewed to check whether certain guidelines were followed in making the determination whether an applicant requires a nursing facility level of care: the guidelines are 7 AAC 140.510 (intermediate level of care), 7 AAC 140.515 (skilled nursing level of care) and the Criteria for Placement in a section of the *Manual for Prior Authorization of Long Term Care Services*. (Department of Health and Social Services, Senior and Disability Services, Policy and Procedure Manual, Older Alaskans Program Eligibility and Enrollment, June 30, 2010; *see,* Ex. 31, p. 17)

The Criteria For Placement, also called the *Manual* factors, are described as follows:

The "Skilled Level of Care" factors are: (1) whether a patient requires 24 hour observation and assessment by a registered nurse or licensed practical nurse; (2) whether a patient requires intensive rehabilitative services, which is defined as 5 days or more per week of physician ordered physical, occupational, respiratory or speech therapy; (3) whether a patient requires 24 hour performance of direct services that must be furnished by a registered nurse, licensed practical nurse or someone acting under their supervision; (4) whether the patient requires medications that are administered

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14 Before February 1, 2010, when the *Manual* was required, by regulation, certain cases applied to mandate consideration of the *Manual* factors. In *Bogie v. State, Division of Senior and Disabilities Services*, Superior Court Case No. 3AN-05-10936 (Decision dated August 22, 2006), the court emphasized that a level-of-care determination may not be made solely on an applicant's CAT score, but must also consider the *Manual* factors and the testimony of the applicant's treating physician. Similarly, in *Casey v. State, Dept. of Health & Social Services, Division of Senior and Disabilities Services*, Superior Court Case No. 3AN-06-6613 (Decision dated July 11, 2007), the court stated that although the level-of-care determination must incorporate the results of the CAT, "[t]he Division must make its final level-of-care decision" based on the guidelines established in the *Manual*. The regulation which formerly incorporated consideration of the *Manual* factors was repealed and the re-enacted regulation did not require consideration of the *Manual* factors.

However, subsequent to the regulatory changes effective February 1, 2010, the *Manual* factors still must be considered as part of the assessment review process because the Division of Senior and Disabilities Services Policy and Procedures Manual so requires. *See,* Exhibit 31, pp.17-18.

either intravenously or by naso-gastric tube; (5) whether the patient has a colostomy-ileostomy; (6) whether the patient has a gastrostomy; (7) whether the patient is on oxygen; (8) whether the patient has a tracheostomy; (9) whether the patient is undergoing either radiation therapy or cancer chemotherapy; (10) whether the patient has sterile dressings that require prescription medication; (11) whether the patient has decubitus ulcers; (12) whether the patient has uncontrolled diabetes; and (13) whether the patient has unstabilized medical conditions requiring skilled nursing, such as a new stroke, new fractured hip, new amputation, being in a coma, terminal cancer, new heart attack, uncompensated congestive heart failure, or new paraplegia or quadriplegia. (*Manual for Prior Authorization of Long Term Care Services; See,* Ex. B, pp. 23-25).

The "Intermediate Level of Care" factors are: (1) whether a patient requires 24 hour observation and assessment by a registered nurse or licensed practical nurse; (2) whether a patient requires restorative services, which include encouraging, assisting or supervising the patient in self-care, transfers, ambulation, positioning and alignment, range or motion, and/or handrail use; (3) whether the patient requires a registered nurse to perform services; (4) whether the patient's use of drugs requires daily observation; (5) whether the patient require assistance with activities of daily living, including maintaining Foley catheters, ostomies, special diet supervision, or skin care with incontinent patients; (6) whether the patient has a colostomy-ileostomy; (7) whether the patient requires oxygen therapy; (8) whether the patient requires either radiation or chemotherapy; (9) whether the patient has skin conditions such as decubitus ulcers, minor skin tears, abrasions, or chronic skin conditions; (10) whether the patient is diabetic and needs daily supervision of diet or medications; and (11) whether the patient has behavioral problems such as wandering, verbal disruptions, combativeness, verbal or physical abusiveness, or inappropriate behavior. (Ex. B, pp. 25-26).

An administrative agency is "bound by [its] regulations unless and until it repeals or amends the regulation using the proper procedure. Administrative agencies are bound by their regulations just as the public is bound by them." *Burke v. Houston NANA, L.L.C.*, 222 P.3d 851, 868 – 869 (Alaska 2010).

ANALYSIS

Burden of Proof and Standard of Proof

Because this case involves an application, Claimant has the burden of proof by a preponderance of the evidence as to all factual issues.

Issue Analysis

The parties agreed at the fair hearing that Claimant challenged the denial of eligibility arising from the August 24, 2010 assessment (assessment) of Claimant and not her June 2, 2010 assessment.

The parties' arguments are essentially the same with regard to Claimant's needs. The parties differ in the emphasis placed on Claimant's behaviors manifested before her admission to API and in the first two months of her stay at API.

The parties' dispute is whether Claimant's needs make her eligible for the Older Alaskans Waiver Program.

Claimant's arguments can be summarized as:

1. Claimant does not need a nursing facility level of care when only the need for skilled nursing facility or intermediate level of care is considered, but does meet the eligibility criteria for a nursing facility level of care as a result of the application of the *Manual* factors. Claimant's Initial Post-Hearing Brief of October 13, 2010 at 10-12.

2. The CAT assessment dominated the eligibility determination and the assessor should have looked at the *Manual* factors independently of the CAT. Claimant's Responsive Post-Hearing Brief of October 22, 2010 at 3.

3. Claimant asserts the reason she is eligible under the *Manual* factors is because a) Claimant needs one-on one observation and assessment to keep her from wandering and "causing trouble for herself and others;" b) Claimant can be non-compliant with taking medication; c) Claimant needs cueing and supervision in regards to activities of daily living; and d) Claimant has manifested inappropriate behaviors. *Id.* at 10.

4. Claimant asserts that an assisted living facility would need "special staff assignments" to provide for Claimant's needs. *Id.* at 12.

The Division's arguments can be summarized as:[15]

1. Claimant's primary needs are for supervision and cueing and she has no physical or nursing needs. State's Closing Brief of October 13, 2010 at 1.

2. Claimant has been diagnosed with progressive dementia, has suffered from confusion and disorientation and wanders. *Id.* at 2-3. Claimant is cooperative with taking medication, does not require IV medication or medication administered on an as needed basis. *Id.* at 5. Claimant follows cueing, and does not require physical assistance to carry out activities of daily living. *Id.* at 5. Claimant's behavioral issues existed in the past but since receiving a medication regimen to treat her dementia a "huge difference" in behavior has resulted. *Id.* at 5.

3. Claimant was determined not eligible for the Waiver Program by applying both the CAT and the *Manual* factors. State's Closing Brief of October 13, 2010 at 7.

The issue is whether the Senior and Disabilities Services Division was correct to deny Claimant's application for Medicaid Home and Community Based Older Alaskans Waiver services because it determined Claimant did not require a nursing facility level of care as of August 24, 2010.

<u>Undisputed Facts Concerning Claimant's Needs</u>

[15] *See also,* Footnote 7.

Claimant's physical condition is not in dispute in this case: Claimant is a physically capable person. Claimant does not need any physical therapies from a qualified therapist or medical treatments administered by a doctor or qualified nursing service provider. It is undisputed Claimant is physically capable of walking and carrying out the activities of daily living.

Claimant needs medication for her dementia and is cooperative in taking it. Taking medication has improved Claimant's behavior. Nonetheless, it is undisputed Claimant, who likes to be outside, is prone to wandering and confusion and Claimant daily needs cueing and supervision to ensure her safety.

The Eligibility Determination for the Older Alaskans Waiver Program

A Home and Community Based Older Alaskans Waiver program eligibility determination is based on an assessment performed by the Division or its designee. 7 AAC 130.230(b). In making an eligibility determination, the department is required to incorporate the assessment results of applying the Consumer Assessment Tool (CAT). 7 AAC 130.230(b)(2)(B). The function of the Consumer Assessment Tool is to determine whether an applicant needs a nursing level of care that is either skilled care (as provided in 7 AAC 140.515) or intermediate care (as provided in 7 AAC 140.510.

Claimant cannot qualify for the Older Alaskans Waiver Program unless her needs require a nursing facility level of care. 7 AAC 130.205(d)(2). In making the determination whether Claimant needs a nursing facility level of care, the Senior and Disabilities Services (Division) assessing nurse and reviewing nurse must:

1. Determine if Claimant requires skilled nursing facility services (7 AAC 140.515) or intermediate care facility services (7 AAC 140.510) and apply and incorporate the Consumer Assessment Tool in making that determination; and

2. Consider whether Claimant's needs fall within the "Skilled Level of Care" or the "Intermediate Level of Care" factors of the *Manual for Prior Authorization of Long Term Care Services*. (*Manual* factors.)

Therefore, the eligibility determination for a Home and Community Based Older Alaskans Waiver Program applicant is based on the CAT and *Manual* factors from which an applicant can be evaluated to require (or not require) a nursing facility level of care. The nursing facility level of care is described as skilled care, provided in 7 AAC 140.515 or intermediate care, described in 7 AAC 140.510.

A. The Consumer Assessment Tool (CAT)

Regulation 7 AAC 130.230(b)(2) requires that the level of care eligibility determination "incorporate" the Consumer Assessment Tool (CAT) assessment into the determination. This language clearly requires the CAT be part of the eligibility determination but does not make the CAT exclusively determinative of the outcome.

The Division's nurse assessor conducted Claimant's assessment by applying the Consumer Assessment Tool (CAT) as required by 7 AAC 130.230(b)(2)(B). Based on the scoring of the questions on the CAT, Claimant scored a total of 1. A score of one (1) is insufficient to support a determination that Claimant's needs require a nursing facility level of care. Claimant needed a score of three (3) or more (as a total of the nursing and activities of daily living factors) to be medically eligible[16] for a nursing facility level of care.

Neither the discussion portion of the CAT nor the scored areas of the CAT show Claimant requires professional nursing care or special treatments or therapies as of the date of the assessment on August 24, 2010.

Claimant did not prove by a preponderance of the evidence that the CAT assessment was incorrect or inaccurate as to Claimant's condition. Claimant's evidence supported the findings of the CAT assessment.

B. *Manual* factors

Consideration of the *Manual* factors is not required by regulation 7 AAC 130.230(b)(2) but is required by the Division's Policy and Procedure Manual, Older Alaskans Program. (Ex. 31, p. 17)

The reviewing nurse compared Claimant's needs to the *Manual* factors and found that Claimant needed only the intermediate level of care factor of assistance with activities of daily living because Claimant needed supervision and cueing with these activities. (Ex. J-2) The assessing nurse determined Claimant's needs did not require a nursing facility level of care.

A review of the *Manual* factors for the skilled level of care and for the intermediate level of care makes clear that Claimant does have needs within the scope of these factors. Claimant's needs are for supervision and cueing but the factors pertain to receipt of specialized treatments or assistance which must be provided by a registered nurse or a licensed practical nurse.

The reviewing nurse noted Claimant's needs in relation to the intermediate level of care factor, number (11) "whether the patient has behavioral problems such as wandering, verbal disruptions, combativeness, verbal or physical abusiveness, or inappropriate behavior." Advanced nursing skills, such as are practiced by a registered nurse or licensed practical nurse, are not needed to provide Claimant with the level of supervision and cueing she needs. The reviewing Nurse determined Claimant's need in regard to this sole factor was insufficient by itself to make Claimant eligible for the Waiver Program.

Claimant was determined not eligible for the nursing facility level of care because she did not need skilled nursing services and did not need intermediate care facility services. The evidence showed Claimant needs general supervision to prevent her from wandering inappropriately, to ensure she takes her prescribed medication, and to cue her to perform activities of daily living, such as hygiene

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[16] Regulation 7 AAC 130.230(b) requires only a determination of medical eligibility, not financial eligibility. Financial eligibility for the Medicaid Waiver services is not part of this case.

activities. Claimant did not provide evidence showing that Claimant's needs required professional nursing skills of the level provided by a nursing facility as contemplated by the *Manual* factors.

C. Conclusion

The determination that Claimant was not eligible for the Waiver Program resulted from both the assessment made using the CAT and from the review of the *Manual* factors. Claimant was found not to need a nursing facility level of care based on the assessment of the CAT and of the *Manual* factors.

The Claimant had the burden of proof in this case. She did not establish either that the August 24, 2010 assessment of the CAT was not correct or that the Division failed to follow its policy requirement to consider the *Manual* factors in making an eligibility determination.

In summary, the Claimant did not show she was eligible for Home and Community Based Older Alaskans Waiver Program when she was assessed on August 24, 2010. The Division was correct when it denied the Claimant's application for this Waiver Program on September 2, 2010, based on the August 24, 2010 assessment.

CONCLUSIONS OF LAW

1. Claimant failed to meet her burden of proving by a preponderance of the evidence that she required either skilled nursing facility level of care or intermediate care facility level of care as of August 24, 2010, the date she was assessed to determine her eligibility for Medicaid Home and Community Based Older Alaskan Waiver services.

2. On August 24, 2010, Claimant did not qualify for Medicaid Home and Community Based Older Alaskan Waiver services.

3. The Division was correct to deny Claimant's application for the Older Alaskans Waiver Program on September 2, 2010.

DECISION

The Senior and Disabilities Services Division was correct to deny Claimant's application for Medicaid Home and Community Based Older Alaskans Waiver services because it determined Claimant did not require a nursing facility level of care as of August 24, 2010.

APPEAL RIGHTS

If for any reason the Claimant is not satisfied with this decision, the Claimant has the right to appeal by requesting a review by the Director. To do this, send a written request directly to:

Kimberli Poppe-Smart, Acting Director
Division of Senior and Disability Services

4501 Business Park Blvd., Suite 24
Anchorage, AK 99503-7167

If the Claimant appeals, the request must be sent within 15 days from the date of receipt of this Decision. Filing an appeal with the Director could result in the reversal of this Decision.

DATED November 26, 2010.

_____*/signed/*_____________________
Claire Steffens
Hearing Authority

CERTIFICATE OF SERVICE

I certify that on this 26th day of November, 2010,
true and correct copies of the foregoing were sent to:

Mark Regan, Esq., Disability Law Center, U.S.P.S. Certified Mail, Return Receipt Requested.

And to the following by email:

Kimberly Allen, Esq., Assistant Attorney General
Neviz Calik-Russel,Esq., Assistant Attorney General
Kimberli Poppe-Smart, Director
[redacted], Policy & Program Development
[redacted], Policy & Program Development
[redacted], Staff Development & Training

_______*/signed/*_______________________
J. Albert Levitre, Jr. Law Office Assistant I