STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing Nos. 20,148
	)	& 20,676
Appeal of	)	

INTRODUCTION

The petitioner appeals a decision by the Department of Aging and Disabilities (DAIL) reducing the number of hours she receives personal care attendant services pursuant to the Choices for Care (CFC) waiver.

Petitioner was transitioned from the Home and Community Based Services (HCBS) waiver to the CFC waiver during December 2005. In doing so, DAIL reduced the hours of service in a decision dated December 12, 2005. Petitioner filed a timely appeal and has been receiving continuing benefits based on the hours she received through the HCBS waiver. Waiver program recipients receive services on an annual basis after submitting reassessments to DAIL.

On March 8, 2006, the prior hearing officer held a status conference. Because DAIL determined that services should be reduced as petitioner transitioned into the CFC program, the question arose whether the criteria for services changed during the transition from the HCBS waiver to the CFC waiver. The parties were to determine what caused the change

in service amounts and determine whether they could reach an agreement. The parties were to notify the Human Services Board if the matter needed to be reset for hearing. The parties subsequently exchanged information, but DAIL did not change its decision.

DAIL sent petitioner a notice December 4, 2006 setting out the personal care (service) hours the CFC waiver would cover for the next service year. Petitioner filed a timely appeal on December 10, 2006.

On December 11, 2006, DAIL filed a Motion to Dismiss because the annual recertification had been completed and a new service plan had been authorized.[1] The petitioner filed an Opposition to the Motion to Dismiss on December 12, 2006 that the underlying issue remained regarding the proposed reduction of service hours. The motions were originally set for January 4, 2007.

In the interim, petitioner filed a Motion for Emergency Status Conference because it appeared that petitioner's hours would be cut pending resolution of the fair hearings. An emergency status conference was held December 29, 2006. DAIL was dealing with the service glitch so that no gaps would

[1] DAIL indicated they would not recoup any of the continuing benefits.

occur in petitioner's services. DAIL's Motion to Dismiss was denied. Petitioner continues to receive continuing benefits.

The case was set for hearing on January 8, 2007. The decision below is based on the evidence adduced at hearing and subsequent briefing of the parties.

FINDINGS OF FACT

1. Petitioner is a fifty-two year old disabled individual with multiple impairments including muscular dystrophy (MD), cerebral palsy (CP), visual impairment, gastric problems due to partial stomach removal, neurogenic bladder, chronic urinary infections, arthritis, chronic pain, and colonization by antibiotic resistant bacteria. Petitioner is wheelchair bound.

2. Petitioner has been able to remain in the community due to the help she receives from the attendant care services programs administered through DAIL.

3. Petitioner has received waiver services from DAIL for the past seven years. Her last reassessment for HCBS waiver services was for the period from December 16, 2004 through December 15, 2005. As a result of that reassessment, petitioner received a variance and 102 hours of services every two weeks. As a HCBS recipient, petitioner was

automatically enrolled in the CFC waiver. Her reassessment seeking a continuation of the 102 service hours every two weeks and variance was submitted on or about November 7, 2005 by Helen Turcotte, Champlain Valley Area Agency on Aging (CVAAA) case manager. On December 12, 2005, DAIL notified petitioner that she would receive 75 hours of service every two weeks for the period of December 16, 2005 through December 15, 2006. Petitioner did not understand how DAIL could reduce her services by 27 hours every two weeks when there had been no positive change to her condition or needs. Petitioner appealed.

4. The HCBS waiver was renewed calendar year 2002. The CFC waiver program started October 1, 2005. HCBS waiver recipients are being incorporated into the CFC waiver program. In Petitioner's case, she was automatically transferred to the CFC program at the conclusion of the December 14, 2004 to December 15, 2005 HCBS waiver service year.

5. In both the HCBS and CFC waiver programs, a case manager submits an Independent Living Assessment (ILA) to DAIL. The ILA is comprised of several sections including an assessment of Activities of Daily Living (ADL), assessment of Instrumental Activities of Daily Living (IADL), and a medical

assessment of the individual's health. The assessment is done in the individual's home by the case manager and registered nurse with the participation of the individual and, if appropriate, family members and personal care attendants. The case manager completes the sections for ADLs and IADLs, and the registered nurse completes the health section. The ADLs include dressing, bathing, personal hygiene, bed mobility, toilet use, adaptive devices, transferring, mobility, and eating. The CFC waiver includes meal preparation and medication management in the ADLs although these are IADLs. The CFC waiver caps the remaining IADLs at 330 minutes per week. Both waiver programs include additional incontinence assistance. The criteria for each ADL and IADL including level of need are the same for both the HCBS and CFC waiver programs. Level of care ranges from:

a) 0 independent
b) 1 supervision
c) 2 limited assist
d) 3 extensive assist
e) 4 total dependence

Both waiver programs include the same maximum time limits for each ADL depending on the level of need. Recognizing that an individual may need time in excess of the maximum time limits, both waiver programs allow the individual to apply for a variance.

6. Turcotte has been petitioner's case manager since 2004. Turcotte has been a case manager with CVAAA for seventeen years and has submitted approximately 400 assessments to DAIL for waiver programs. When completing assessments, Turcotte takes into account other services a recipient receives and does not include those services in her requests. Turcotte found the assessment form for the HCBS and CFC waiver programs to be similar. Turcotte explained she had a problem with the forms because the forms do not take into account those times when additional services are needed because a recipient may be sick. She does take these situations into account when completing the assessment. According to Turcotte, she is conservative when completing assessments and rarely asks for variances.

7. Turcotte met with petitioner and Marie Seegersteen-Lorrain, R.N., Medicaid Waiver Coordinator for the Visiting Nurse Association, on November 7, 2005 to complete the assessment form for the December 15, 2005 to December 16, 2006 services. They met with petitioner for two hours. According to Turcotte, the R.N. assesses medical conditions and how those medical conditions impact functional status. Turcotte took into account that petitioner receives LNA

services through the Care Connection; the LNA ordinarily is at petitioner's home in the morning for 1-1.5 hours daily.

8. Turcotte found that petitioner needed total assistance for the majority of her ADLs. Turcotte requested:

Activity	Level of Need	Minutes/day req.
Dressing	4[2]	30
Bathing	4	45
Personal Hygiene	4	20
Bed Mobility	4	20
Toilet Use	4+	60
Adaptive Devices	3	10
Transferring	4+	45
Mobility	4	30
Eating	4	45
Meal prep	max.	75
Medication manag.	1	5

Turcotte also found that petitioner needed 20 minutes at three days/week to assist with urinary incontinence and the maximum for IADLs of 330 minutes per week. Turcotte submitted a request for 102 hours every two weeks and a variance request. Turcotte's request was basically the same as the request she submitted the prior year under the HCBS waiver program. As part of the functional assessment, Turcotte noted:

1. Dressing: Limited range of motion due to MD and poor vision make dressing difficult for petitioner.

[2] Four is the highest level of need and is divided into two sections; less than six times per day and more than six times per day. Four plus is for more than six times per day.

2. Bathing: Petitioner needs bathing assistance between LNA visits due to G tube leakage.

3. Personal Hygiene: Needs help because spills food when eating. Cathing 8 times per day; needs help washing.

4. Bed Mobility: Too sick to get out of bed at least twice per month.

5. Transferring: More than 6 times per day due to fractured foot.

6. Mobility: Petitioner is in a wheel chair. Needs to be propelled when uses manual chair.

7. Eating: Attendant maintains the G tube. Some solid meals (two per day and snacks).

8. Meal preparation: Please look at last year's variance request; no change in status.

9. After submitting the assessment, Turcotte was called by Toni Morgan, DAIL Long Term Care Clinical Coordinator (LTCCC). Turcotte suggested Morgan call the petitioner.

10. Morgan is one of twelve regional LTCCCs. Morgan is a R.N. and became a LTCCC in October 2005 at the start of the CFC waiver program. Morgan has prior experience assessing functional abilities of participants in DAIL programs for over 20 years. Approximately eight to nine years before the hearing, Morgan evaluated petitioner for services in the PDAC program. Prior to the hearing, Morgan last saw petitioner about two years ago at a social function.

11. Morgan had questions regarding the ILA and called petitioner. Morgan spoke to petitioner for less than an hour. After speaking with petitioner, Morgan reduced a number of the ADLs from total dependence to extensive assistance. The changes were:

Activity	Level of Need	Minutes/day req.
Dressing	3	15
Bathing	3	20
Personal Hygiene	3	15
Adaptive Device	4	10
Transferring	4	25
Mobility	1	5
Eating	3	30
Meal Prep		60

Morgan approved petitioner for 75 hours of service every two weeks. Morgan did not make a decision on petitioner's variance request.

12. Morgan testified that she clarified the LNA duties with petitioner. Then, Morgan made one change by subtracting time for tasks the LNA did. Morgan did not clarify with Turcotte whether the LNA's time had been factored into the assessment. Turcotte had factored in the LNA time before completing the assessment. This time should not have been deducted by Morgan from the assessment.

13. During her testimony, Morgan explained the changes she made. Morgan believed that petitioner could assist with

dressing by helping put on her top, that petitioner could help with bathing by washing her face and front and around the G tube, that her mobility needs were less because she was in a motorized wheelchair and needed help with doors, that petitioner can feed herself in terms of the solid food she consumes during the day, and that the transfers should be reduced because she is ordinarily in her wheelchair during the course of the day. Morgan did not speak with petitioner's medical providers and did not meet personally with the petitioner.

14. Turcotte testified that she did not understand the reductions made by Morgan. Turcotte believes that the reductions are too drastic and jeopardize petitioner's care needs.

15. Dr. Robert Luebbers testified on behalf of the petitioner at the hearing. Dr. Luebbers is a board certified family practice physician at Fletcher Allen Health Care. He has been petitioner's primary care doctor since 1998 and has provided care in her home. According to Dr. Luebbers, nutrition is a major challenge. The G tube is used to provide petitioner with needed calories. The tube needs to be kept clean to avoid recurring infections. Petitioner is intermittently catheterized during the day. The catheter

needs to be kept clean to guard against infections, especially given petitioner's history of urinary tract infections. Petitioner had been hospitalized six times over the six to seven months prior to the hearing; hospitalizations were primarily due to urinary tract infections. In addition, petitioner's MD is regressing and is in the process of being reevaluated. Dr. Luebbers testified that petitioner's hours should not be reduced based on his medical assessment of her condition.

16. Petitioner submitted a letter from Segersteen-Lorrain dated July 6, 2006.[3] Seegersteen-Lorrain does not support the proposed reduction in hours. She noted the need for frequent tube feedings and need for frequent cathing. The G tube leaks causing additional cleaning and changing of clothes. Additional feedings take additional time. She noted that they took into consideration additional time to keep the equipment clean given petitioner's increased risk of infection.

17. Petitioner testified that she first received approximately 51 hours every two weeks in attendant services

[3] Petitioner initially submitted this letter to DAIL during ongoing discussions. This letter was part of the DAIL case record and was subsequently accepted as part of the hearing record.

from DAIL in 2000 or 2001. Petitioner believes her needs will increase as she ages.

18. Petitioner remembered being called by Morgan. According petitioner, she did not have the paperwork Morgan was referring to and did not realize what the definitions meant. She feels that there was miscommunication between the two of them.

19. Petitioner testified that she needs a great deal of care. Her G tube does not fit properly, in part due to weight fluctuations. The G tube needs to be cleaned to keep from being clogged. Depending on the leakage, petitioner may need to have her clothes changed or to have another shower. During this past year, petitioner started administering medications through the G tube adding to the need of cleaning the G tube. Petitioner receives nutrition through the G tube and through meals and snacks.[4] Petitioner is hypoglycemic and has several small meals per day. Petitioner has trouble swallowing and needs her food cut into small pieces. Petitioner needs someone with her while eating if she starts to choke. According to petitioner, she is ill about two times per month. As a result, she remains in bed which

[4] When the case began, petitioner received nutrition during the day through the G tube. Now, petitioner receives nutrition through the G tube at night.

necessitates additional transfers. According to petitioner, once she is in bed at night, a personal care attendant living in the same apartment complex will return to help with her positioning in bed. She testified she can manage her sleeves with some help.

20. Petitioner's personal care attendants will change petitioner's soiled clothing, wash where the leakage from the G tube has soiled petitioner's skin, give showers if warranted by circumstances, and clean the wheelchair seat pad if warranted. The personal care attendants also clean the G tube as needed, usually associated with feeding or giving medication through the G tube. These actions cause additional transfers as well as additional work for the personal care attendants. The personal care attendants cut up petitioner's food in small pieces and place them in the refrigerator at a height petitioner can manage to reach.

21. For the December 16, 2006 through December 16, 2007 service year, Turcotte submitted a service plan and variance for 97 hours every two weeks taking into account changes to food preparation and medications as well as the need for additional personal hygiene assistance beyond the LNA services due to the G tube leakage. Morgan approved a service plan for 79.5 hours every two weeks but did not act

on the variance. Petitioner does not agree with either of these assessments.

ORDER

DAIL's decision is reversed consistent with this decision.

REASONS

Congress established the Medicaid program as a cooperative federal and state program:

> to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care. . .
>
> 42 U.S.C. § 1396.

State participation is voluntary. However, once a state elects to participate in the Medicaid program, the state must submit a state plan and comply with certain Congressional requirements. 42 U.S.C § 1396a, Harris v. McRae, 448 U.S. 297, 301 (1980).

To provide the states latitude in meeting the medical needs of their residents, Congress permits a State to apply for a Medicaid Waiver in which the State receives permission to waive certain requirements of the Medicaid program. One

of the areas Congress has targeted for Medicaid Waivers is home health care and services to prevent institutionalization; 42 U.S.C. § 1396n(c)(1) provides:

> The Secretary may by waiver provide that a State Plan approved under this subchapter may include as "medical assistance" under such plan payment for part or all of the cost of home and community-based services ...which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination **that but for the provision of such services the individuals would require the level of care provided in a hospital or nursing facility. . .**emphasis added).

See 42 C.F.R. § 441.300.

DAIL has opted to develop waiver programs to help individuals such as petitioner remain in their homes and communities rather than being institutionalized. In doing so, DAIL has submitted specific waiver requests to the Centers for Medicare and Medicaid Services for approval.

When DAIL approved petitioner for services under the HCBS waiver, DAIL made a determination that petitioner required nursing home level care. As part of the HCBS waiver, petitioner submitted annual reassessments. Based on these reassessments, petitioner received a variance and a total of 102 service hours every two weeks starting in 2000 or 2001.

The HCBS waiver has built-in limits. Individuals faced waiting for a slot to open up for community care services or

choosing nursing home placement. To remedy this defect and provide eligible individuals equal access to either nursing homes or community based services, DAIL started the CFC waiver. CFC became operational on October 1, 2005.

The CFC waiver grandfathered HCBS waiver participants into CFC through a phase-in. See Special Terms and Conditions of Approval from the Centers for Medicare and Medicaid Services, Section IV, paragraph 21 and Vermont Long-Term Care Plan ("[t]he result is to essentially "grandfather" in the population currently served. . .through the Aged and Disabled 1915(c) waivers. . ." at page 27). Grandfathering of HCBS waiver participants was incorporated in the CFC, Vermont Long-Term Care Medicaid, Program Manual, Higher and High Needs, Section II C.

As a result of the grandfathering provisions, DAIL transitioned petitioner into the CFC program upon her annual reassessment for the service year starting December 15, 2005. Because petitioner is grandfathered into the CFC waiver, petitioner cannot be considered a new applicant whose eligibility needs to be determined. Petitioner is an eligible participant whose service needs are annually reviewed through the reassessment process. CFC 1115 Long-Term Care Regulations, Section VII(B).

The reassessment process and the assessment tool (ILA—Independent Living Assessment) used in for the HCBS and CFC waivers are virtually identical. The real difference stems from the CFC waiver incorporating two IADLs (food preparation and medication management) into the computations for the ADLS and capping the remaining IADLs at 330 minutes per week.[5]

Petitioner's case manager submitted the reassessment for the service year starting December 15, 2005 to DAIL requesting a continuation of the 102 service hours every two weeks and a continuation of the variance. However, DAIL's response was quite different leading to a significant proposed reduction in service hours from 102 to 75 per two week period.

Petitioner timely requested a fair hearing. DAIL has recognized the right of aggrieved individuals to contest a denial, reduction, or termination of CFC services. In fact, DAIL incorporated the right of individuals to seek redress pursuant to the Human Services Board statute and rules in their waiver and subsequent regulations. CFC 1115 Long-Term Care Regulations IX.

[5] DAIL has designated different staff to review the assessments and reassessments; however, there is no indication or information in the regulations that the criteria for determining the levels of care and time limits are different for the two waiver programs.

The parties differ on the nature of petitioner's legal interest in the CFC benefits and who has the burden of proof in this case. The petitioner argues that DAIL has the burden of proving the basis for reducing her ongoing service hours. DAIL argues that petitioner has the burden of proving they were wrong in reducing petitioner's service hours. To understand the allocation of the burden of proof, we need to first look at petitioner's property interest in her service hours, and the due process rights which flow from that property interest.

The genesis of the fair hearing process is Goldberg v. Kelly, 397 U.S. 254 (1970). The Supreme Court in the Goldberg case recognized that welfare recipients had a property interest in their welfare benefits and that due process attached when the state proposed terminating or reducing those benefits. Due process includes advance written notice setting out the state's action, the rationale for that action, and the right of the recipient to challenge the state's decision through a fair hearing.

Courts have recognized the property rights of Medicaid recipients. See Cantazano v. Wing, 103 F.3d 223 (2nd Cir. 1996)(right to fair hearing whenever services are denied); Granato v.Bane, 74 F.3d 406 (2nd Cir. 1996)(termination of

HCBS waiver services upon hospitalization is agency action triggering due process requirements); 42 C.F.R. § 431.201. These property rights extend to Medicaid waiver recipients. Boulet v. Cellucci, 107 F.Supp.2d 61 (D. Mass. 2000); Cramer v. Chiles, 33 F.Supp.2d 1342 (S.D. Fla. 1999), Martinez v. Ibarra, 759 F.Supp. 664 (D. Colo. 1991).

Weaver v. Colorado Dept. of Social Services, 791 P.2d 1230 (1990) is instructive. Colorado used a point system to determine eligibility for their HCBS waiver program. Weaver received services for two years. Although there was no change in Weaver's medical and physical condition, he was denied services. The Court noted that the different scores may reflect the different attitudes of the evaluators. Further, the court stated at page 1235:

> . . .if an individual has once been determined to be eligible for social service benefits, due process prevents a termination of these benefits absent a demonstration of a change in circumstances, or other good cause.

Moreover, the Board rules recognize that state agencies bear the burden of proof. Fair Hearing Rule No. 11 states:

> The burden of proving facts alleged as the basis for agency decisions to terminate or reduce an assistance grant, or to revoke or fail to renew a license, shall be on the agency, unless otherwise provided by statute.

DAIL argues that they do not have the burden of proof based upon Husrefovich et al. v. Department of Aging and Independent Living, 2006 Vt. 17, 898 A.2d 726 (VT 2006). In Husrefovich, the Court affirmed a decision reducing HCBS waiver service hours noting the Board's findings of fact that the petitioners were receiving the appropriate level of HCBS waiver services based on the petitioners' medical needs.

Here, the factual question remains whether DAIL's proposed reduction of petitioner's service hours reflects the appropriate level of CFC waiver services hours based on petitioner's functional and health needs. Petitioner was already eligible for CFC waiver services; the purpose of the reassessment was to compute the appropriate level of services. Petitioner's situation is similar to other individuals facing redetermination or reassessment of their benefits from other programs administered by the Agency of Human Services (DAIL's parent agency) such as the amount of RUFA or Food Stamps, the amount of a Medicaid spend-down, etc. Any time the agency proposes adverse action based upon such a redetermination, the agency bears the burden of proof in a fair hearing.

Accordingly, DAIL has the burden of proof in this case. Before there can be a finding that petitioner does not need

the same service hours as in the past, DAIL needs to show a factual basis supporting a reduction of service hours.

DAIL has not met their burden of proof in this case.

DAIL is charged with delivering long-term care services that "protect the health and welfare of the individuals receiving services". C.F.C. 115 Long-Term Care, Medicaid Waiver Regulations, II and VII.B.6. As part of the reassessment process, the LTCCC reviews the ILA looking at both the health and functional needs of the individual. During the reassessment, the LTCCC may meet with the individual, case manager, or others involved in the individual's care. There is no requirement that the LTCCC meet with the individual or others knowledgeable about the individual's health and functional capacities. However, in a case where the LTCCC is proposing a significant reduction in an individual's services, it is a better practice for the LTCCC to meet with the individual and appropriate people to ensure that the LTCCC can support her/his recommendations. This was not done in this case.

In Petitioner's case, she has received a consistent level of services for at least three years prior to her transition to the CFC waiver program. Her health and functional needs have remained constant. Based on the

information from petitioner and those involved in her care and assessment there was no basis for a change for the service year starting December 15, 2005. The case manager did indicate slight changes for the service year starting December 15, 2006.

In addition, Morgan had no basis to reduce petitioner's service hours by assuming that petitioner's LNA services were not factored into the ILA. Petitioner offered credible testimony at hearing that Turcotte factored in petitioner's LNA services and computed petitioner's service hour request after subtracting the LNA services.

At the hearing, DAIL mentioned that petitioner's past HCBS waiver service hours were not supported by need because of problems in the prior assessment process. However, DAIL did not provide any testimony supporting this position. Moreover, the earlier Husrefovich case was triggered by DAIL adopting maximum time limits for each ADL and IADL in order to bring consistency to their assessments. Petitioner has been through this process, and, as a result, we can infer that her assessments are consistent with other program assessments.

It is important to note that the ILA and assessment criteria have remained constant across waiver programs.

Petitioner presents complex needs based on her complex health needs and resulting functional limitations. DAIL has not provided sufficient evidence to support a decision that petitioner's functional capacity has changed causing a diminution in her needs.

Petitioner also argues that DAIL has not followed CFC requirements to act upon petitioner's request for a variance. DAIL has not directly addressed this argument, perhaps believing that their thoughts on the variance request could be inferred from their decision setting petitioner's service hours. However, the CFC program requires a separate decision and notice on variances. CFC Vermont Long-Term Medicaid Manual, Section V.8. DAIL was remiss in not sending a written decision regarding the variance request.

Accordingly, DAIL's decision is reversed. Petitioner should be awarded the service hours and variance noted in the respective ILAs submitted by the case manager.

3 V.S.A. § 3091(d), Fair Hearing Rule No. 17.

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