



FILED  
APR 24 2014

BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS  
STATE OF GEORGIA

APR 24 2014

*K. Westray*

Kevin Westray, Legal Assistant

<p><b>Petitioner,</b></p> <p>v.</p> <p><b>DEPARTMENT OF COMMUNITY HEALTH,</b></p> <p><b>Respondent.</b></p>	<p>:</p> <p>:</p> <p>:</p> <p>:</p> <p>:</p> <p>:</p> <p>:</p> <p>:</p> <p>:</p>	<p><b>Docket No.:</b></p> <p><b>Agency Reference No.:</b></p>
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**INITIAL DECISION**

**I. INTRODUCTION**

The hearing in this matter was held on March 19, 2014<sup>1</sup> before the undersigned administrative law judge of the Office of State Administrative Hearings. The hearing's purpose was to review Respondent's decision to terminate Petitioner's benefits under a Medicaid program known as "SOURCE." Attorney Mary Irene Dickerson, Esq. appeared on Petitioner's behalf, and Yvonne Hawks, Esq. represented Respondent, Department of Community Health ("Department"). After consideration of the evidence and the arguments of the parties, the Department's decision to terminate Petitioner's benefits is hereby **AFFIRMED IN PART AND REMANDED.**

<sup>1</sup> Petitioner filed post-hearing briefing on April 7, 2014, and Respondent submitted a responsive pleading on April 14, 2014.

## II. FINDINGS OF FACT

### A. SOURCE Program

1.

The Department offers enhanced case management and home and community-based services (“HCBS”) to eligible Medicaid members under a waiver program entitled Service Options Using Resources in Community Environments or “SOURCE.” In the past, the benefits offered through the SOURCE program were part of the Georgia state plan for Medicaid. In 2008, the Department sought and received approval from the Centers for Medicare and Medicaid Services (“CMS”) to remove the SOURCE program from the state plan and place it under the HCBS Waiver for Elderly and Disabled Individuals (“Waiver”). (Testimony of Lorrie Stewart; Exhibits R-1; R-2.)

2.

In order to be eligible for the SOURCE program under the Waiver, an individual must be (1) elderly or physically disabled and (2) meet the intermediate nursing home level of care. Under the first criterion, an individual is part of the Waiver’s target group if he or she is either age 65 or older or has a physical disability. Under the second criterion, an individual meets the “nursing home level of care” if he or she would require care in a nursing facility but for the provision of HCBS. This is considered the intermediate nursing home level of care. (Testimony of Stewart; Exhibit R-2.)

3.

Once an individual is found eligible for the SOURCE program, the Department’s policy manual provides that the individual must be reevaluated by a licensed nurse at least annually to confirm that the individual continues to meet the criteria for the required level of care. The

SOURCE Manual outlines procedures for completing the reevaluation, which include completion of two assessment instruments entitled the MDS-HC Assessment and the SOURCE Level of Care Placement Instrument, also known as Appendix I. These instruments are used to determine an individual's current physical and cognitive functioning and their need for assistance with activities of daily living ("ADLs"), such as bathing, dressing, toileting, walking, or feeding, and independent activities of daily living ("IADLs"), such as housekeeping, meal preparation, taking medications, and using the telephone. In order to qualify for SOURCE services, a member must have one unmet need in his or her activities of daily living, or ADLs. (Testimony of Stewart; Exhibits R-1; R-2; R-5.)<sup>2</sup>

4.

After the nurse completes the reassessment, the Georgia Medical Care Foundation ("GMCF"), reviews the individual's case and determines whether he or she is still eligible for the SOURCE program. Specifically, the medical team reviews the information on the MDS-HC Assessment Tool, and other documentation collected by the nurse, and evaluates the applicant's eligibility under a rubric found in Appendix I of the SOURCE Manual. (Testimony of Stewart; Testimony of Robin Aldridge; Exhibits R-1; R-7.)

5.

Appendix I is a rubric used to determine whether an individual meets the intermediate nursing home level of care.<sup>3</sup> (Exhibit R-1; R-7.) There are three columns in Appendix I –

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<sup>2</sup> Petitioner's post-hearing brief appears to collapse ADLs and IADLs, for example, suggesting that Petitioner is "unable to do most of the activities of daily living" such as "getting to items out of the deep freezer. . . or [doing] any real household chores." (Petitioner's post-hearing brief at p. 2.) Many of the activities detailed are actually IADLs. However, the Waiver specifies that "the individual must have at least one unmet need in an ADL in order to be eligible." (R-2 at p. 23) (emphasis added.)

<sup>3</sup> Appendix I provides that an individual must have either a mental or functional impairment, in addition to a medical condition that meets the nursing home level of care. "The mental status must be such that the cognitive loss is more than occasional forgetfulness" and fits into one of the following four categories: (1) documented memory deficits, (2) documented moderately or severely impaired cognitive skills with etiologic diagnosis for daily decision making,

Medical Status, Mental Status and Functional Status. As a baseline, the intermediate nursing home level of care criteria provides that services may be provided if, under the Medical Status column, an individual “[r]equires monitoring and overall management of a medical condition(s) under the direction of a licensed physician.” In addition, the individual must have an additional medical need under the Medical Status column, such as nutrition management, monitoring of vital signs, or management and administration of medications. Further, the individual also must have at least one documented impairment under either the Mental Status or Functional Status column to meet the intermediate nursing home level of care. An example of a “mental status” impairment that would meet the nursing home level of care in Appendix I is “[d]ocumented moderately or severely impaired cognitive skills with etiologic diagnosis for daily decision making.” An example of a “functional status” impairment under Appendix I is the need for assistance with feeding. (Exhibits R-1; R-7.)

**B. Petitioner's Enrollment in SOURCE**

6.

Petitioner is a sixty-six year old woman who, due to her degenerative bone disease, receives disability payments from the Social Security Administration. In addition to degenerative bone disease, she also has diagnoses of heart disease, asthma, osteoporosis, depression, chronic ischemic heart disease, glaucoma, lumbago and has had a stroke. Petitioner lives in her sister's home with her nephews and boyfriend. Petitioner's sister and nephews only reside at the home sporadically because of their work schedules. SOURCE provides Petitioner

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(3) problem behavior, such as wandering or verbal abuse that requires supervision or intervention, or (4) undetermined cognitive patterns. To meet the functional status component of the rubric, an individual must have one of the following functional impairments or needs: (1) transfer and locomotion performance requiring limited or extensive assistance of staff, (2) assistance with feeding, (3) direct assistance to maintain continence, or (4) communication deficits in making self understood or understanding others. (Exhibit R-5.)

with three hours of services every other day. Services include meal preparation, housekeeping and laundry. (Testimony of Petitioner; Exhibit R-5.)

7.

Petitioner has been receiving SOURCE benefits for a number of years.<sup>4</sup> She qualifies as a member of the target population because she is both elderly and physically disabled. In 2011 the Department moved to terminate Petitioner's SOURCE benefits, but then rescinded its action. Nonetheless, in its most recent assessment the Department concluded that she no longer qualifies for SOURCE because Petitioner's physical condition does not meet the intermediate nursing home level of care. (Testimony of Stewart; Exhibit R-2.)

8.

In July of 2013, Robin Aldridge, a nurse, conducted a routine reassessment of Petitioner's eligibility for SOURCE benefits. Ms. Aldridge has performed assessments for SOURCE cases for the past three years. According to the MDS-HC Assessment completed by Ms. Aldridge, Petitioner has not been hospitalized within the last 90 days. The MDS-HC assessment did not note any issues with her cognition, mood or communication, other than minimal difficulty with her vision. (Exhibit R-5.)

9.

As to her IADLs, the MDS-HC assessment reflects that Petitioner indicated that she needed limited assistance with meal preparation, housework, walking stairs and shopping. In contrast, Ms. Aldridge determined that Petitioner could independently perform all of her IADLs with no impairment. (Testimony of Aldridge; Exhibit R-5.)

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<sup>4</sup> Petitioner argues that since she has received SOURCE benefits for years, the Department should be obligated to demonstrate that her condition has changed such that she is no longer eligible for SOURCE. Albeit there was evidence indicating that Petitioner previously had broken and/or fractured several bones, diminishing her ability to perform either ADLs or IADLs, the only issue before the undersigned is whether she is currently eligible for benefits.

10.

As to her ADLs, the MDS-HC indicated that Petitioner needed supervision/oversight or cueing regarding bathing, and setup help only with walking (Petitioner uses a cane). She had gone out of the house for the past three days. (Testimony of Aldridge; Exhibits R-5; R-7.)

11.

The evidence demonstrated that Petitioner also told Ms. Aldridge that she was not fatigued, takes care of her sister's dogs, and although she has moderate, intermittent pain, she walks to the mailbox each day, traversing several steep steps. When speaking to Ms. Aldridge, Petitioner rated her health as "good." She also told Ms. Aldridge that she and her boyfriend go dancing on occasion. Ms. Aldridge observed Petitioner waiting by the mailbox when she arrived for the assessment, and she walked Ms. Aldridge out to the driveway following the assessment. Ms. Aldridge observed her walking with a steady gait. (Testimony of Aldridge; Exhibit R-5.)

12.

Petitioner vigorously contested the Department's findings as incomplete and/or inaccurate. For example, she noted that at least one portion of the MDS-HC regarding hospitalizations and/or doctor's appointments had not been completed. In her testimony, Ms. Aldridge indicated she did not know why she did not complete those portions of the reassessment, but had not noticed this omission previously. (Testimony of Aldridge.)

13.

Although Petitioner admitted that she had made the statements reported by Ms. Aldridge concerning her capacity, she testified that she had minimized her difficulties because she did not want to admit her incapacity either to Ms. Aldridge or to other caseworkers. For example, Petitioner stated she had fallen about a month ago, but she did not report this to Respondent

because she does not like having to admit she is disabled. Further, the MDS-HC indicated that Petitioner does not wear dentures. At the hearing, Petitioner stated that she does wear dentures. She admitted that she had been reluctant to share this information with Ms. Aldridge because she was embarrassed. (Testimony of Petitioner.)

14.

Renee Rivers is Petitioner's SOURCE case manager, and has been her case manager for two years. She calls Petitioner monthly and visits her every three months. Ms. Rivers agreed Petitioner was not a "complainer." (Testimony of Renee Rivers.)

15.

In the past when Ms. Rivers has visited, Petitioner has met her at the driveway and they have walked to the front door together. Petitioner told Ms. Rivers that her aide cleaned the house and cooked, and that she liked the aide to be in the home when she was bathing. During her most recent visit, in March 2014, Petitioner indicated to Ms. Rivers that she had bad bones and that her muscles were deteriorating. (Testimony of Rivers.)

16.

Catherine Harris is Petitioner's aide. She has been going to Petitioner's home for four years, three times per week. Ms. Harris does all the housework, helps Petitioner with bathing and putting on clothing, prepares meals, does laundry, picks up her medicine, and does the grocery shopping. Ms. Harris stated that Petitioner gets around slowly and gets winded quickly. She helps Petitioner in and out of the shower, and steadies her while she is getting dressed, but agreed that Petitioner could dress herself if necessary. Ms. Harris observed that it is difficult for Petitioner to go up and down the stairs, that her gait is very slow and unsteady, and that she has never seen her get the mail. She doesn't know if Petitioner bathes on the days she does not

come, and doesn't think Petitioner has the stamina to clean. She confirmed that Petitioner wears dentures. (Testimony of Catherine Harris.)

17.

After hearing the witnesses' testimony, the undersigned concludes that Ms. Aldridge's assessment of Petitioner's physical condition is accurate. Both Ms. Aldridge and Ms. Rivers noted after personal observation, that Petitioner was able to traverse steep steps and walk to her mailbox. They also saw that she had a steady gait. Petitioner herself admitted that her health was "good" and that she took care of her sister's dogs. Even if Ms. Harris is correct as to Petitioner's diminished ability to perform general housekeeping duties, her need for assistance with IADLs, in and of themselves, would not qualify her for the SOURCE program. Moreover, as the Department has moved to terminate Petitioner's benefits on a prior occasion, it is not credible that Petitioner would minimize her inability to perform ADLs, given the consequences of this minimization.

18.

Diana Davis is an RN administrator with Unihealth Source. She reviewed the MDS-HC prepared by Ms. Aldridge, and also indicated that she also had reviewed records from Petitioner's primary physician, SOURCE Care Management Progress Notes, and hospital discharge records. She prepared Appendix I, or the SOURCE Level of Care Criteria Checklist, based on these materials. Other than the MDS-HC Assessment, Respondent did not submit any of these additional materials as evidence during the hearing. (Testimony of Diana Davis; Exhibit R-7.)



19.

The Appendix I prepared by Ms. Davis indicates that Petitioner does not meet the intermediate nursing home level of care. Although the Medical Status Column of Appendix I states that Petitioner requires monitoring and management of a medical condition under the care of a physician for her pain, depression, asthma and osteoporosis, and that she also needs monitoring of her vital signs and laboratory studies, the Mental Status column noted no impairments. Under the Functional Status column, Appendix I indicated that Petitioner needed stand-by supervision or cueing to complete dressing or personal hygiene. Appendix I notes that if "this is the only evaluation of care identified another deficit in functional status is required." Ms. Davis also testified that she has spoken with Petitioner's primary care physician, Dr. Chetti, and that he concurred with her assessment. Although the signature itself is illegible, Exhibit R-8 does indicate that a physician has certified that Petitioner did not meet the intermediate level of care. Petitioner did not contest the validity or authenticity of this signature at the hearing. (Testimony of Davis; Exhibits R-7; R-8.)

20.

On January 10, 2014, Petitioner injured her shoulder and currently cannot lift her arm above 90 degrees. She requested Respondent reassess her condition, but Respondent declined to perform a reassessment because it concluded that Petitioner's shoulder injury would not qualify her for SOURCE under the intermediate nursing home level of care.<sup>5</sup>

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<sup>5</sup> Petitioner did submit a number of medical records as evidence in this case; however, it is not clear that these records supported Petitioner's position that she met the level of care necessary to qualify for SOURCE. The vast majority of these records predated the Assessment performed in 2013, and many were over five years old. The most recent medical record, dated January 10, 2014, indicated that Petitioner's "shoulder can lift about 90 degrees" and that her shoulder was improving. There is no written indication by the physician that this condition, or any other condition, would impair her ability to perform her ADLs. Progress notes dated November 25, 2013, also indicate that Petitioner went to the Emergency Room and she was given painkillers, but the hospital records were not tendered.

21.

On October 3, 2013, Respondent sent Petitioner Appendix Z, notifying her that it was terminating her SOURCE services because "You don't meet criteria for Intermediate Nursing Home Level of Care (pursuant to Section 801.3 of the SOURCE manual) as detailed by the attached appendix I (Assessment indicates that it is NOT necessary for you to reside in a Nursing Home for the elderly or physically disabled)." The letter indicated she should call her case manager, Renee Rivers, if she did not understand the notice and provided Ms. River's telephone number. (Exhibit R-3.)

### **III. CONCLUSIONS OF LAW**

1.

This matter concerns Respondent's termination of Petitioner's benefits; therefore, Respondent bears the burden of proof. Ga. Comp. R. & Regs. r. 616-1-2-.07. The standard of proof is a preponderance of evidence. Ga. Comp. R. & Regs. r. 616-1-2-.21.

2.

Medicaid is a joint federal-state program that provides comprehensive medical care for certain classes of eligible recipients whose income and resources are determined to be insufficient to meet the costs of necessary medical care and services. 42 U.S.C. §§ 1396-1396v. Each state is required to designate a single state agency to administer its Medicaid plan. In Georgia, that agency is the Department. 42 C.F.R. § 431.10(a); O.C.G.A. § 49-2-11(f).

3.

The Department offers HCBS to elderly and disabled individuals through its SOURCE program. The SOURCE program is now part of the Department's Elderly and Disabled Waiver,

which was approved by CMS to furnish HCBS to Medicaid recipients who, in the absence of such services, would require Medicaid-covered care in a nursing facility. See 42 C.F.R. § 441.301(b)(1)(iii). “Once approved, the Waiver application becomes the controlling document.” Susan J. v. Riley, 616 F. Supp. 2d 1219, 1240 (M.D. Ala. 2009).

4.

Within the broad Federal rules applicable to Medicaid, the Department is authorized to determine “eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.” 42 C.F.R. § 430.0. See also O.C.G.A. § 49-4-142(a) (the legislature authorized the Department to adopt and administer the state plan for Medicaid, including establishing “the amount, duration, scope and terms and conditions of eligibility for and receipt of such medical assistance...”). Pursuant to this authority, the Department established specific guidelines for nursing home level of care determinations in Appendix I of its SOURCE policy manual. See generally Ga. Comp. R. & Regs. r. 350-1-.02(3) (“The Department [of Medical Assistance] shall publish the terms and conditions for receipt of medical assistance in Policies and Procedures Manuals for each of the categories of service authorized under the State Plan.”).

5.

The Department proposes that, under the standards set forth in Appendix I, Petitioner does not meet the intermediate nursing home level of care required for the SOURCE program. The undersigned concludes that, based on the Findings of Fact, the agency is correct in its determination that Petitioner does not meet the intermediate nursing home level of care. Petitioner then raises several procedural issues regarding the proposed termination. First, Petitioner argues that the agency failed to specify the reason for the intended action, as required

by its policy manual. Second, Petitioner states that the agency failed to comply with the manual's requirement that the agency obtain the physician's signature in cases of termination due to the failure to meet level of care. Third, Petitioner maintains that the agency failed to engage in and notify Petitioner about its process of pre-termination discharge planning.

6.

Petitioner argues that the notice sent by the Department was not reasonably calculated to provide Petitioner with the basis upon which it decided to terminate her benefits under the SOURCE program, such that she was unable to prepare and present relevant testimony to rebut Respondent's allegations. On October 3, 2013, Respondent sent Petitioner Appendix Z, notifying her that it was terminating her SOURCE services because "You don't meet criteria for Intermediate Nursing Home Level of Care (pursuant to Section 801.3 of the SOURCE manual) as detailed by the attached appendix I (Assessment indicates that it is NOT necessary for you to reside in a Nursing Home for the elderly or physically disabled)." The letter indicated she should call her case manager, Renee Rivers, if she did not understand the notice and provided Ms. River's telephone number. (Exhibit R-3.) Petitioner objects to the content of this notice, pointing out that not only must Appendix Z specify the reason for termination, but that the manual requires Appendix Z articulate "why the member does not meet the [level of care] criteria" and also cite applicable policy in support. (R-1 at p. 81).

7.

The underlying purpose of the federal notice requirements is to ensure that states "meet the due process standard set forth in Goldberg v. Kelly, 397 U.S. 254, 267-68 (1970) (holding that a recipient of public assistance must "have timely and adequate notice detailing the reasons for a proposed termination, and an effective opportunity to defend by confronting any adverse

witnesses and by presenting his own arguments and evidence orally.”); Nix v. Long Mountain Resources, 262 Ga. 506 (1992) (due process at its core is right of notice and opportunity to be heard). In this case, although the notice neither indicates why Petitioner did not meet the level of care criteria nor cites to applicable policy, Appendix I and the MDS-HC Assessment, both of which Petitioner and her attorney received prior well over a month prior to the hearing date, provides this information. Moreover, on February 19, 2014, Petitioner requested and received a continuance in this case for numerous reasons – including that she was not sufficiently prepared to proceed – but never argued that there had been insufficient notice by the Department. During the hearing, Petitioner was able to cross examine adverse witnesses and present evidence and testimony. Given these circumstances, Petitioner received adequate notice in this case.

8.

Petitioner also argues that the agency failed to follow its requirement that it obtain a physician’s signature in the case of a termination due to the failure to meet level of care. Although the Department did not offer any response to this argument in its post-hearing briefing, the undersigned notes that Exhibit R-8 does indicate that a physician has certified that Petitioner did not meet the intermediate level of care. Petitioner did not contest the validity or authenticity of this signature at the hearing.<sup>6</sup>

9.

Finally, Petitioner maintains that Respondent did not meet its burden regarding discharge planning. The manual specifies that “appropriate discharge planning and referral assistance will be provided to the member by the case manager throughout the 30-day notification period.”

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<sup>6</sup> Perhaps Petitioner is referring to the manual’s provision that “[p]rior to review by the Interdisciplinary team, the nurse (R.N. or L.P.N.) shall review the member’s diagnoses, medications, treatments with the member’s [primary care physician] to ensure concurrence with the Member’s health and functional status as documented on the MDS-HC.” (Exhibit R-1 at p. 80.) In this case, there was testimony that the Department reviewed Petitioner’s condition with her primary care physician, Dr. Chetti.

(Exhibit R-1 at p. 80.) It also notes that the interdisciplinary team, with the case manager, will review other resources to meet the member's needs.

10.

Although the SOURCE Manual does not detail specific requirements regarding discharge planning, by way of analogy, Medicaid requires that participating hospitals plan for each patient's hospital discharge. Among other things, the regulations require hospitals to identify those patients who need a discharge plan and provide an evaluation to those patients and any others who request an evaluation. 42 C.F.R. § 482.43(a)-(b)(1). The evaluation must be timely so that arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge. 42 C.F.R. § 482.43(b)(5). The hospital must transfer or refer patients to appropriate facilities, agencies, or outpatient services for follow-up or ancillary care. 42 C.F.R. § 482.43(d).

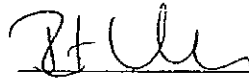
11.

In this case, the Department did not provide sufficient evidence that it had provided the member with discharge planning or referral assistance during the 30-day notification period. Given that Petitioner has relied on the SOURCE program for years for meal preparation and housekeeping assistance, it is imperative that the Department meet its obligation in at least attempting to assist her in obtaining replacement services before terminating SOURCE benefits.

**IV. DECISION**

For the foregoing reasons, Respondent's decision to terminate Petitioner's enrollment in the SOURCE Program is **AFFIRMED**, however the case is **REMANDED** to the Department for discharge planning for a period of thirty days. The Department may not terminate Petitioner's benefits until it has complied with its obligation to provide discharge planning.<sup>7</sup>

**SO ORDERED**, April 23, 2014.



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**Ronit Walker**  
**Administrative Law Judge**

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<sup>7</sup> For example, it is possible that Fayette Senior Services at [info@fayss.org](mailto:info@fayss.org) might be able to provide Meals on Wheels or housekeeping services to Petitioner.