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

In the Matter of	)	
	)	
L D	)	OAH No. 18-0011-MDS
	)	Agency No.

DECISION

I. Introduction

L D is a developmentally disabled woman who receives day habilitation services as part of her Medicaid Waiver plan of care. An October 1, 2017 regulation change places new limits on the number of day habilitation hours a Medicaid recipient may receive. A recipient may now receive no more than twelve hours per week of day habilitation, unless additional hours are necessary to protect the recipient's health and safety and to prevent institutionalization. For her 2017-2018 plan of care, and based on the change to its regulations, the Division of Senior and Disabilities Services approved L for only twelve hours of weekly day habilitation, denying the remaining eight hours per week that were requested. L, through her guardian, appealed the Division's determination. Because the evidence at hearing established that L more likely than not does require more than twelve hours of day habilitation to protect her health and safety and to prevent institutionalization, the Division's decision to deny the additional eight hours per week of day habilitation is reversed.

II. Facts

A. Background

L is a 31-year-old woman with developmental delays and a primary diagnosis of intellectual disability.[1] L's most recent ICAP scoring reflects functional ages of 4 years, 8 months in the domain of Broad Independence;[2] 4 years, 1 month in the domains of social and communication skills and personal living skills;[3] and 5 years, 8 months in the domain of community living skills.[4] In addition to her intellectual disability, L's secondary diagnoses

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1 Ex. E, p. 4.
2 Ex. E, p. 19.
3 Ex. E, p. 20.
4 Ex. E, p. 21.

include unspecified mood disorder, high body mass index, metabolic syndrome, and frequent incontinence.[5]

L lives in No Name City with her mother, M M-D. Members of her care team describe her fondly as "sweet and helpful," and an "amazing," "wonderful" individual.[6] However, L experiences considerable difficulty regulating her emotions.[7]

L "has a low frustration level and anger issues,"[8] and "often" gets "overwhelmed and emotional."[9] When she is overwhelmed or upset, she "has emotional breakdowns."[10] As described at the hearing, when L is frustrated, she reacts with anger, defiance, aggression, and physical demonstrations, including banging her own head, breaking things that belong to herself or others, and sometimes making threatening physical gestures.[11] Because of L's size – 5' 7" and approximately 315 pounds – she can be very threatening, physically.[12] She "sometimes resorts to physical violence if not assisted" when "frustrated and angry."[13] Within the last few months, L has threatened her mother with a knife, pulled her mother's hair while her mother was driving a car, and opened the passenger door of a moving car.[14] She has also threatened suicide, as well as threatening violence against her mother.[15] While these examples of extreme behavior occur less frequently, L has angry outbursts several times a week.[16] These behaviors have made it very challenging for her mother, a single mother recovering from a difficult bout with cancer, to keep L living at home.[17]

L enjoys being active in the community, but requires considerable support to do so. She participates in the Special Olympics, a disability-accessible dance group, and other community activities.[18] However, "[s]he is unable to attend events [in the community] without transportation or support."[19] Ms. M-D's recent health problems make it difficult for her to play as active a role

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5 Ex. E, p. 4.
6 Ex. E, p. 19; Z testimony; M-D testimony.
7 Ex. E, pp. 21-22; M-D testimony.
8 Ex. E, p. 21.
9 Ex. E, p. 18.
10 Ex. E, p. 18.
11 M-D testimony; Ex. E, p. 21.
12 M-D testimony.
13 Ex. E, p. 21.
14 M-D testimony.
15 M-D testimony; Ex. E, p. 21 (POC: "L has a very low self-esteem and spoke of suicide").
16 M-D testimony.
17 M-D testimony.
18 Ex. E, p. 18; M-D testimony.
19 Ex. E, p. 17.

in L's community engagement as she has in the past.[20] She credits L's ability to participate in community activities to her "supportive, caring staff who've learned her triggers, signs, and numerous problem areas" in a way that helps them foresee and prevent trouble, "talk her down," and "prevent violence."[21]

As the Division's witness acknowledged, being "out in the community" is beneficial to L, helping her "manage her anxiety and episodes of negative behavior."[22] By the same token, lack of access to community engagement and activity is a particular source of anxiety, frustration, and anger for L.[23] She "has meltdowns when not getting out enough or [if she] is to[o] overwhelmed."[24] While L sometimes has "emotional outbursts" and "los[es] her temper" during outings,[25] most of her outbursts occur during the times of the day when she is alone with family, rather than in the community.[26] L "has a very strained relationship" with her family, and "has a lot of meltdowns and [negative] behaviors when with her mother and siblings."[27] She "likes going into the community without her family," and "gets depressed when not getting out and keeping active."[28]

When L has experienced a decrease in her day habilitation hours, the effect on her mental health and critical behaviors has been noticeable and uniformly negative. During the summer of 2017, a care provider's sudden, unexpected resignation left the family unable to fill L's scheduled day habilitation time. During the six weeks it took to resolve the staffing/scheduling situation, L's behavior deteriorated across contexts. As recalled by Ms. M-D, L was "angry all the time," "argumentative," "fighting," "banging her head," "threatening suicide," "throwing stuff," "wouldn't shower" and displayed "intense emotions."[29]

L's family is very protective of her and the desire to ensure her needs are met. The family is also distrustful of law enforcement and social services agencies that they feel might misinterpret L's behaviors or react to them in a manner that fails to account for her disability and

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20 M-D testimony.
21 M-D testimony.
22 Aasland testimony.
23 Ex. E, p. 17; M-D testimony; B affidavit.
24 Ex. E, p. 21.
25 Ex. E, p. 18.
26 Ex. E, p. 17; M-D testimony.
27 Ex. E, p. 17; M-D testimony.
28 Ex. E, p. 17.
29 M-D testimony.

needs.[30] As a result, L's mother has not always reported behavioral difficulties to her team, attempts to minimize the incidents she does report, and tries to take whatever steps are necessary to deescalate behavioral situations before they rise to the level that would trigger a critical incident report.[31] Because of these dynamics, L's own care team was not fully aware of some of her aggressive behaviors at home prior to beginning the fair hearing process.[32]

B. L's plan of care

L receives waiver services through the Individuals with Developmental Disabilities ("IDD") program. Her services include supported living, individual day habilitation, daily respite, hourly respite, and transportation. L's day habilitation services are the subject of the current dispute.

1. 2016-2017 plan of care

L's plan of care for December 10, 2016 through December 9, 2017 provided for the following:

1. Individual Day Habilitation – avg. of 20 hours per week for 52 weeks or 4,160 units
2. Supported Living – avg. of 40 hours per week for 52 weeks or 8,320 units
3. Hourly Respite – 520 hours or 2,080 units
4. Daily Respite – 14 days or 14 units
5. Transportation – avg. of 3 one-way rides per week for 52 weeks or 156 units.[33]

The plan described L as "very high maintenance," with "behavior difficulties in the form of tantrums and defiant behavior," and noted the challenges her care places on her mother, who was in treatment for lung cancer.[34]

The plan described L's Day Habilitation services as assisting her "in the acquisition, retention and improvement of socialization and adaptive skills in a community-based setting," and providing "opportunities to participate in community activities and events so that she can develop natural supports and friendships."[35] Her day habilitation goals included multiple objectives around planning and accessing social opportunities in the community, including both activity planning and appropriate social behavior; identifying and communicating the need for sensory breaks; and using "appropriate safety actions."[36]

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30 M-D testimony; T testimony.
31 M-D testimony; T testimony.
32 Z testimony.
33 Ex. F, pp. 5, 6, 7, 16.
34 Ex. F, p. 5.
35 Ex. F, p. 16.
36 Ex. F, p. 17.

2. Changes to the day habilitation regulation

In August 2017, the Department amended certain Medicaid regulations, including the regulation governing day habilitation hours. The changes went into effect on October 1, 2017. Under the revised regulation:

> The department will not pay for more than 624 hours per year of any type of day habilitation services from all providers combined, unless the department approves a limited number of additional day habilitation hours that were
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> (1) requested in a recipient's plan of care; and
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> (2) justified as necessary to
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> (A) protect the recipient's health and safety; and
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> (B) prevent institutionalization.[37]

Care coordinators were notified of this change via email on September 11, 2017.[38] The notice reflected that plans of care received after October 1 would be "reviewed in light of the new limit on day habilitation services." Providers were advised that "[r]equests for service amounts exceeding the yearly cap will be considered exceptions to the rule and should only be requested in extreme circumstances." The email explained that the Division would review such requests "to determine whether a limited amount of additional day habilitation hours are necessary to protect a recipient's health and safety and to prevent institutionalization," and that such reviews would be undertaken "in the context of individual's (sic) entire service plan and person centered goals."

3. 2017-2018 Plan of Care

In October 2017, L's Care Coordinator, Y Z, submitted a plan of care for services from December 10, 2017 through December 9, 2018.[39] Because of the team's strong belief that reducing L's day habilitation services would be detrimental to her well-being, the 2017-2018 plan of care provided for the same level of service – including day habilitation – as under the prior year's plan.[40]

L's 2017-2018 plan again describes her as "very high maintenance," with "behavior difficulties in the form of tantrums and defiant behavior."[41] Additionally, various sections of the plan describe L's anxiety, need to spend time out of the home, and increased behavioral

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37 7 AAC 130.260(c).
38 Ex. 1, p. 10.
39 Ex. E.
40 *Compare*, Ex. E *with* Ex. F; Z testimony; M-D testimony; T testimony; B affidavit.
41 Ex. E, p. 27.

problems when unable to spend enough time in the community. The "overall life situation" of her plan includes that L:

- "Gets overwhelmed by family pressure and needs time away from home;"
- "Often has challenges dealing with the family dynamics;"
- "States that she needs breaks from her family and how important having staff outside of the family unit is to her;"
- "Looks forward to Day Habilitation when she has one-on-one staff helping her away from the family unit;" and
- "Has severe melt downs and overloads when not out of the home enough." [42]

The plan also expresses a concern that reducing L's day habilitation hours would "increase her melt downs" and "impact her drastically emotionally."[43]

The description of her "social environment" includes notes that L"

- "Likes going into the community without her family;"
- "Needs supports to be [] and feel [safe] in the community setting;"
- "Is unable to attend events without … support;"
- "Has to be accompanied during social events due to her level of social skills;"
- "Gets depressed when not getting out and keeping active;" and
- "Needs ongoing support to handle the emotional struggles."

The plan also reports that "increased activity and social outing[s] are the only things that truly help" with "her behaviors and depression."[44]

The description of L's "community living skills" states that she "has had many episodes of challenging behavior and emotional out bursts these last several years," and that "the less she is out in the community, the more depressed, withdrawn, and negative she gets."[45] The description of her "situational limitations" includes her "low frustration level and anger issues," and having "frequent crying jags [requiring] help focusing on the positive."[46] The description of "what works and does not work" includes that L "has meltdowns when not getting out enough or is to[o] overwhelmed."[47] And the plan identified L's "critical behaviors" as including low self-esteem, including talking about suicide; anger and frustration, sometimes including physical

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42 Ex. E, p. 8.
43 Ex. E, p. 8.
44 Ex. E, p. 18.
45 Ex. E, pp. 18, 21.
46 Ex. E, p. 21.
47 Ex. E, p. 21.

violence; behavior that can "quickly change to aggression;" and throwing tantrums "when tired, overloaded, or frustrated."[48]

As with the previous year's plan, the 2017-2018 plan indicates that day habilitation services will be used "to assist in the acquisition, retention and improvement of socialization and adaptive skills in a community-based setting," and give L opportunities to participate in community activities and events so that she can develop natural supports and friendships."[49] The plan expresses concern that reduction from L's existing number of day habilitation hours would adversely impact L's "health and safety," noting that she "melts down and falls into severe depressions when home to[o] much," and "has severe crying jags, angry outbursts and dangerous behaviors that manifest [when she] is not out and active enough!"[50]

Like the previous year's plan, L's day habilitation goals include objectives related to planning events, using appropriate social skills, and identifying and communicating emotional needs.[51] The plan also includes an additional goal of improved positive interpersonal relationships, with objectives and methods relating to positive social interactions and "respond[ing] to conversations when she is upset and emotional."[52]

C. Division's review and partial denial

L's plan of care renewal was assigned for review to Glenda Aasland, a Health Program Manager I in the Division's IDD unit. Ms. Aasland did not believe that the plan of care sufficiently documented a need for day habilitation in excess of the presumptive maximum of twelve hours per week.[53] She did not feel that the plan of care provided enough details about the severity and frequency of L's problematic behaviors.[54] She also believed that the plan showed L was functioning well in being able to "access community on her own" with Medicaid-provided transportation.[55]

Ms. Aasand's view that the regulation's exception was not triggered was also influenced by her conclusion that there was insufficient information to support that L was "at risk of

48 Ex. E, p. 21.
49 Ex. E, p. 39.
50 Ex. E, p. 39.
51 Ex. E, p. 40.
52 Ex. E, p. 43.
53 Aasland testimony; Ex. D.
54 Aasland testimony.
55 Aasland testimony.

institutionalization within thirty days" if the requested level of support was not provided.[56] As discussed below, the regulation's invocation of preventing institutionalization is not limited to a thirty-day imminent risk time frame.

On December 20, 2017, the Division notified L's guardians of the partial denial of her plan of care amendment. The Division approved the following:

1. Individual Day Habilitation – avg. of 12 hours per week for 52 weeks or 2,496 units
2. Supported Living – avg. of 40 hours per week for 52 weeks or 8,320 units
3. Hourly Respite – 520 hours or 2,080 units
4. Daily Respite – 14 days or 14 units
5. Transportation – avg. of 3 one-way rides per week for 52 weeks or 156 units.[57]

Citing 7 AAC 130.217 and 7 AAC 130.260, the Division denied the remaining Individual Day Habilitation sought (an average of eight hours per week).[58]

The denial letter cited the changed regulations for day habilitation services.[59] While the letter acknowledged the plan's references to meltdowns and outbursts when L is not in the community enough, the letter criticized a lack of "specific examples of what these behaviors look like and how often they occur."[60] The letter also noted that the approved plan would provide L with an average of 62 hours per week – or nine hours per day – of waiver services, and concluded that: "[t]his level of support when combined with other natural and community supports appears to be of sufficient scope, amount, and duration to accomplish the intent of the POC and to prevent institutionalization."[61]

D. Appeal

L's guardians timely appealed the partial denial. The hearing on L's appeal was held on February 14 and March 2, 2018.[62] The hearing was telephonic. The Division was represented by fair hearing representative Terri Gagne. Division Health Program Managers Glenda Aasland and Heather Chord testified on behalf of the Division. Present and testifying on L's behalf were:

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56 Aasland testimony.

57 Ex. D, p. 1.

58 Ex. D, p. 1.

59 Ex. D, p. 2.

60 Ex. D, p. 2. The letter also raised questions about the nature of the day habilitation services being provided, and whether they might overlap with L's supported living services (specifically, in that both services contain goals related to L's physician-ordered physical exercise requirements).

61 Ex. D, p. 3.

62 As described further below, after Ms. Aasland's testimony on the first day of hearing, L's family asked for a continuance so they could gather and provide evidence to respond to the concerns she had raised. The continuance was granted over the Division's objection, and the hearing resumed on March 2, 2018.

L; her mother and guardian M M-D; her care coordinator Y Z; her direct care provider B B; Consumer Direct Service U J; and Consumer Direct Service T T.[63]

III. Discussion

A. Scope and nature of administrative appeal process

As a threshold issue, a dispute arose during this proceeding about the scope and nature of review in an administrative appeal. These are questions that have been previously decided and are matters of established law. But because both the Division's representative and its witnesses asserted positions during the hearing that are contrary to the established law on this issue, we begin with a discussion of these procedural issues.

When the hearing began, Ms. Aasland's testimony focused on what she saw as shortcomings in the plan of care – a failure to specifically enumerate specific instances of critical behaviors. It is worth noting here that the plan of care document doesn't ask for these; it just asks what the critical behaviors are. L's plan of care identified her critical behaviors as including violent outbursts, suicidal ideation, tantrums, and "meltdowns." Nonetheless, Ms. Aasland testified that the plan is insufficient to show a nexus between the requested services and the prevention of institutionalization because there was insufficient detail about the specific nature and frequency of these behaviors.

Following this testimony, the family asked for a continuance so that it could provide those details to the Division and/or through this proceeding. The Division opposed both requests, arguing that it could not now consider any new information, and, further, that it would be inappropriate for the administrative law judge to consider such evidence. The Division contended that the only evidence the administrative law judge was permitted to consider was the evidence before the Division at the time the denial was made, and that consideration of any evidence that had not been submitted to the Division at that time would be inappropriate, and would amount to allowing the family to seek a new amendment through the hearing process.

The Division was flatly wrong about the appropriate procedures, and the administrative law judge granted the continuance over its objection. The family was seeking to offer evidence to demonstrate that L is entitled to the level of services that had been requested in the plan of care at issue in this appeal. This is not the same as seeking an amendment. The family was not

[63] L and Ms. B were not present for the second day of hearing, but submitted affidavits in lieu of live testimony. The Division did not object to these submissions.

seeking to add additional services at the hearing phase that weren't previously requested – for example, they were not, mid-hearing, suddenly wanting to add additional respite hours. Instead, they were looking to offer evidence to support the existing request. This was an entirely reasonable request and one that that falls squarely within the parameters of the administrative appeal process.[64]

As the Division's representatives should well know, this issue has been established in numerous prior cases. As summarized in a 2013 Commissioner decision:

> The standard of review in a Medicaid 'Fair Hearing' proceeding, as to both the law and the facts, is de novo review. The substantial evidence test is the standard of review that would be applied to factual determinations only after a final decision is made by the agency and an appeal is made to the Superior Court. Likewise, the reasonable basis test is the standard of review for questions of law involving agency expertise only after a final decision is made by the agency and the case is appealed to the Superior Court.
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> In this case, evidence was presented at hearing that was not available to the Division's reviewers. The administrative law judge may independently weigh the evidence and reach a different conclusion than did the Division's staff, even if the original decision is factually supported and has a reasonable basis in law. Likewise, the Commissioner is not required to give deference to factual determinations or legal interpretations of his [her] staff [or] its contractors.[65]

The purpose of an administrative appeal is to produce an agency's final and best decision based on the best evidence available. It would not serve the purpose of either the day habilitation regulation or the fair hearing process to limit the inquiry to what is contained in the documents that were submitted prior to the Division's decision. Indeed, if such a limitation were appropriate, there would be no purpose in allowing live testimony at a hearing.

Now that L's family has appealed the Division's decision, the matter goes to the Commissioner or her designee to make a best and final agency decision. The day habilitation regulation indicates that, where day habilitation hours are requested beyond the presumptive maximum of twelve, the issue turns on (1) whether the hours were requested in the plan of care (they were) and, (2) if so, whether *the Department* determines those hours are necessary to protect her health and safety and prevent institutionalization. The fair hearing process is part of that determination, and it is wholly appropriate to consider all available evidence as to whether

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64 7 AAC 49.120(3)(D) (hearings "related to the administration of the Medicaid program" are "de novo").

65 *Matter of M.L., Jr.*, OAH No. 13-1572-MDS, at 8 (Comm'r of Health and Social Services, April 2014). *See also, Matter of T.C.*, OAH No. 13-0204-MDS, at 9 (Comm'r of Health and Social Services, October 2013) (disregarding evidence relevant to eligibility at the time of the Division decision, as requested by Division, "would risk undermining existing agency policy," and Division has failed to show "that it is a wise and legally sound approach").

the hours sought in the plan of care are appropriate. Indeed, to refuse to do so, as the Division urged, would be an abuse of discretion.

B. Burden of proof

A second procedural issue that arises in this case is the burden of proof. Typically, if the Division is proposing a reduction in the level of services, it bears the burden of proving the reduction is appropriate.[66] An exception exists, however, if the reduction is solely due to a change in the law.[67] Here, the reduction was solely due to the change in regulations. L's family therefore bears the burden of proving, by a preponderance of the evidence, that the reduction is inappropriate under the regulation. That is, they must prove that L requires more than the presumptive maximum of twelve hours of day habilitation in order to protect her health and safety and to prevent institutionalization.

C. "Prevention of institutionalization" under the regulations

A third preliminary issue to address is the concept of risk of institutionalization for purposes of this case. While the revised regulations limit the number of weekly habilitation hours to twelve unless more is necessary to protect the recipient's health and safety and prevent institutionalization, the regulations do not define or quantify the risk of institutionalization associated with this exception. Nor do they identify what type of placement constitutes an "institution."

In terms of identifying the level of risk of institutionalization, Ms. Aasland indicated she applies the standard set out in 7 AAC 125.026(g). That regulation – governing a different Medicaid program – defines "risk of institutionalization" in the context of that program to mean that withdrawal of services would likely result in institutionalization within the next 30 days.[68] But that regulation does not apply here. First, it is a regulation about service level authorization for personal care services, and by its terms is self-limiting to that situation. There is no authority for applying the PCS regulation here, and no apparent justification for construing the waiver regulation's reference to the "prevention of institutionalization" to mean "a risk of institutionalization within the next thirty days." The 30-day standard set out in 7 AAC 125.026(g) does not apply here.

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66 7 AAC 49.135.

67 *See* 42 C.F.R. 431.220(b).

68 7 AAC 125.026(g) ("In (f) of this section, "risk of institutionalization" means it is likely that as a result of the recipient's current condition as identified in assessments and medical records, the recipient would require relocation from the recipient's current residence to a hospital or nursing facility in 30 days.").

Of course, if a policy decision were made to apply a thirty-day standard in the Waiver context, the department could promulgate a Waiver regulation similar to § 125.026(g) and, after gathering and considering public comment, could adopt it as law. But it has not done so.

To apply a blanket 30-day standard without the benefit of a statute or duly issued regulation would directly contravene the limits the Alaska Supreme Court has placed on agency action. For example, in *Noey v. State, DEC*, the Department of Environmental Conservation had applied a blanket five-acre threshold in connection with an environmental health standard. The Supreme Court invalidated decisions the department had made under that threshold, pointing out that such a "rule of thumb" is nothing but a regulation in disguise—and an illegal one, since it has not been properly adopted.[69]

Further evidence that 30 days is the wrong standard can be found in the department's regulation for screening Waiver applicants. Initial applicants are screened to determine "whether there is a reasonable indication that the applicant might need services at [an institutional level of care] in 30 or fewer days unless the applicant receives home and community-based waiver services under this chapter."[70] In other words, Waiver eligibility for an applicant receiving no waiver services is triggered where there is a risk of institutionalization within 30 days. It cannot be that day habilitation hours beyond the presumptive twelve per week are only authorized where the totality of a recipient's other Waiver services is so insufficient to meet the recipient's needs that the recipient is at the same risk of imminent institutionalization as an applicant receiving no Waiver services.

Neither the language of the regulation nor the spirit of the Waiver program supports this restrictive a reading. While the regulation is plainly intended to limit recipients' use of day habilitation services, it is possible that such services can be "necessary to prevent institutionalization," even if withdrawing them will not lead to the *imminent* institutionalization required by the standard applied by Ms. Aasland. Rather, because the decision being appealed is the approval or denial of a year-long plan of care, the appropriate standard is whether the plan of care, so modified, will be sufficient to prevent institutionalization during the plan year.

In terms of the meaning of institutionalization, this necessarily turns on the nature of the waiver program. The purpose of the waiver program is to offer eligible recipients "opportunity

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69 *Noey v. Department of Environmental Conservation*, 737 P.2d 796, 806 (Alaska 1987).

70 7 AAC 130.211(a).

to choose to receive home and community-based waiver services as an alternative to institutional care."[71] As a waiver recipient in the IDD category, L is eligible for waiver services as an alternative to an intermediate care facility for individuals with intellectual disabilities (an ICF/IID).[72] Logically, the risk of institutionalization referred to in the regulation is the type of institutionalization that waiver care is designed to replace. Accordingly, in this circumstance, the question is whether a reduction of her day habilitation hours will place L at risk for placement in an intermediate care facility (or any other institutional facility of equivalent or greater restrictiveness) during the course of the plan year.

D. Has the family shown that more than twelve hours per week of day habilitation services are necessary to protect L's health and safety and prevent institutionalization?

With all of the foregoing as context, the question then is whether L's family has shown, by a preponderance of the evidence, that more than twelve hours per week of day habilitations services are necessary to (1) protect her health and safety, and (2) prevent institutionalization. The answer to that question is yes.

The evidence establishes:

- That L's mental health problems are significantly exacerbated by a lack of community engagement;[73]
- That L requires assistance to engage with the community;[74]
- That when she lacks access to the community, L behaves in aggressive and sometimes violent ways;[75]
- That L's mother's recent health problems limit the availability of other "natural supports" that might otherwise be available;[76]
- That L's team made a good faith effort to identify other possible outlets for her need for community engagement.[77]

L's care team describes the plan as designed to prevent her from being institutionalized, and expresses concern that, "if this time is taken away, you will in fact see her institutionalized,

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71 7 AAC 130.200.

72 7 AAC 130.205(d)(3) ("[T]o qualify for this recipient category the applicant must (A) meet the criteria specified in 7 AAC 140.600(c) and (d); and (B) require, as determined under 7 AAC 130.215, a level of care provided in an ICF/IID").

73 M-D testimony; B affidavit; D Affidavit.

74 M-D testimony; B affidavit; D Affidavit.

75 M-D testimony

76 M-D testimony

77 Z testimony

you will see her have to have officers called, you will see all the negative things this current plan has prevented."[78]

At the hearing, the testimony of both Division witnesses focused on their view that L's plan of care does not contain the level of specificity they would associate with a recipient needing more than the presumptive maximum of twelve hours per week of day habilitation. As noted, however, both witnesses then insisted that it was improper, in determining L's needs, to consider the additional evidence submitted at hearing, including her mother's detailed descriptions of violent, aggressive behavior.

Ms. Aasland was critical of the plan of care for not including details (such as the frequency of critical behaviors) that the plan document does not actually ask for. The testimony of L's family and care team credibly filled in gaps to establish that the critical behaviors occur frequently (several times per week), and can include aggression and threats to herself and to others.

Ms. Aasland insisted that a reduced level of day habilitation would not put L at risk of institutionalization because she still receives an average of nine hours per day of services. But this testimony ignores the evidence – in documents as well as family and care provider testimony – that it is specifically the lack of access to community activity that most reliably triggers L's destructive and negative behaviors. On this issue, the credible testimony of L's care team about the individualized nature of the request for more than twelve hours based on L's particular needs was more persuasive than Ms. Aasland's generalizations about what level of other services is generally sufficient to meet a recipient's needs.[79]

Ms. Chord's testimony on direct examination was credible as to her initial impressions of the plan of care in the context of other IDD waiver recipients whose needs rise to the level of requiring institutionalization. But Ms. Chord was not credible when asked, following the close of respondent's case, whether the testimony and other new evidence about L's actual functioning changed that analysis. Ms. Chord first declined to answer, stating (wrongly) that it would be improper to consider that evidence because it was not before the Division at the time of the decision being appealed. Ms. Chord then requested a break before finally answering, with little explanation, that the testimony did not change her perspective because L's behaviors described at

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78 T testimony.

79 *See* Z testimony; M-D testimony; T testimony; B affidavit.

the hearing had not "risen to the level where a critical incident report needs to be filed or law enforcement needs to be brought in."

This testimony was less credible because of Ms. Chord's reluctance to answer the question and strong opposition to considering the evidence presented at hearing. Even when she eventually did answer, she ignored credible family and caregiver testimony about why critical incident reports had not been filed; failed to address whether the behavior described in fact warranted a CIR, even if one was not actually filed; and imposed a standard by which a recipient receiving nearly twice the hours the division now proposes to provide must have required law enforcement intervention at that much higher level of services.

While the amended regulation undoubtedly creates a standard for additional day habilitation hours, that cannot be the standard. The evidence at hearing established that even with the previously approved level of day habilitation services, L functions dangerously close to the edge of physical danger, law enforcement involvement, and institutionalization. It is more likely than not that reducing her weekly hours from twenty to twelve will further jeopardize her health and safety, and create a risk of institutionalization.

IV. Conclusion

The evidence presented at hearing established that the additional hours of day habilitation requested over the presumptive maximum of twelve per week are necessary to protect L's health and safety and to prevent institutionalization. Accordingly, the Division's decision is reversed.

Dated: March 6, 2018

Signed
Cheryl Mandala
Administrative Law Judge

Adoption

The undersigned, by delegation from the Commissioner of Health and Social Services, adopts this Decision, under the authority of AS 44.64.060(e)(1), as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 20th day of March, 2018.

By: *Signed*
Name: Kathryn A. Swiderski
Title: Administrative Law Judge

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