NON-ADOPTION DECISION

The undersigned, by delegation from the Commissioner of Health and in accordance with AS 44.64.060(e)(3) revises the proposed disposition of the case as set forth below, and adopts the proposed decision as revised:

The record demonstrates that the requested amendment to the Person Centered Support Plan is not adequately documented to determine whether the plan is sufficient to maintain him in the community, as required by 7 AAC 130.217(b)(1). Although the amendment asserts a need for additional services, it does not accurately identify or document the change of circumstances under 7 AAC 130.217(d) that would justify the additional services requested. Moreover, the testimony in this case presents a rationale for additional services different from that documented in the amendment through the person-centered planning process. This testimony suggests that the support plan renewal authorized in February may now be insufficient because of a change of circumstances related to the recipient's health, safety, and welfare that was not adequately documented in the May amendment, underscoring the need for the request to return to the care planning team for further development.

A. Necessary Clarification of Change in Circumstances and Amendment under 7 AAC 130.217(d)

The cover page of the support plan amendment submitted May 9, 2025 states that the recipient "needs acuity due to his size, inability to move himself and the care that he needs."[1] Those needs were already present when the prior support plan renewal was approved in February 2025, and the medical records submitted with the May amendment do not show a material worsening of diagnosis or severity between February and May. This raises the key question: *what change led the planning team to conclude that additional services were necessary to maintain him in the community and to file an amendment under 7 AAC 130.217(d) requesting acuity?*

The support plan narrative elsewhere does expand on the request, but still only in general terms. For example, it states that the guardian has privately hired supplemental caregivers to keep the recipient safe, but that her retirement funds are nearly depleted and she cannot continue privately paying for such care.[2] Notably, the section of the support plan amendment that describes the goals and objectives for the acuity services frames the request in terms of meeting ADL and IADL needs such as medication reminders, hygiene, toileting, and prompting.[3] These are habilitative objectives that fall within Family Home Habilitation already authorized and the medical records submitted with the amendment do not show a material worsening of diagnosis or severity between February and May that would require additional assistance with these tasks. Under the Conditions of Participation for Residential Habilitation Services, which includes Family Home Habitation, services "must be planned with the objective of maintaining or improving the recipient's physical, mental, and social abilities *rather than rehabilitating or restoring such abilities*" [Emphasis added].[4] The amendment does not demonstrate that additional acuity staffing is required to meet these habilitative goals.

At hearing, however, the recipient's guardian credibly testified that the true basis for the amendment was not additional habilitative needs, but her declining physical capacity, impending

---

1 Exhibit E, p. 2.
2 Exhibit E, p. 13.
3 Exhibit E, p. 28-29.
4 Residential Habilitation Services Conditions of Participation, adopted by reference in 7 AAC 160.900(d)(45) (available at https://health.alaska.gov/media/3pxnuklz/residentialhabilitationservicescop.pdf).

retirement, and inability to continue filling in for gaps in skilled care. She explained that she has historically provided skilled medical interventions when private duty nurses were unavailable, including skilled medical interventions like suctioning, nebulizer treatments, chest percussion therapy, pulse oximetry, specialized feeding, seizure management, medication administration, bowel/bladder care, and range of motion exercises that are identified in the recipient's current Nursing Oversight and Care Management plan.

The current Nursing Oversight and Care Management plan lists four individuals trained and authorized to perform such skilled medical interventions under the recipients authorized waiver support plan.[5] Notably, the guardian herself is not among the four.[6] From an authorization standpoint, her provision of these skilled interventions therefore constituted informal family support, not an authorized waiver service.

The guardian's testimony persuasively established that this supplemental support is no longer available. She credibly stated that without additional service, she would seek institutional placement for the recipient. This reduction in available support constitutes a "change of circumstances related to the health, safety, and welfare of the recipient" under 7 AAC 130.217(d) and demonstrates that the current service configuration is insufficient to maintain the recipient in the community. This would be consistent with how the loss of any primary caregiver might constitutes a "change of circumstances related to the health, safety, and welfare of the recipient" under 7 AAC 130.217(d). However, as submitted, the May 9th amendment request therefore does not sufficiently identify the specific "change of circumstances" required by 7 AAC 130.217(d)(1)(A) or (B) or satisfy the requirements for authorization of acuity services under 7 AAC 130.267.

B. Person-Centered Planning Requirements under 7 AAC 130.218

Under 7 AAC 130.218, support plans must be developed through a person-centered planning process that includes the active participation of the recipient, the recipient's representative, and the planning team. The Department's role is to approve or disapprove the plan submitted under 7 AAC 130.217, not to unilaterally substitute its own service determinations for those of the planning team.

In this case, the Division of Senior and Disabilities Services (SDS) modified the amendment request by substituting a reduced service configuration rather than approving or disapproving the plan as submitted. SDS then made an independent sufficiency finding under 7 AAC 130.217(b), despite the absence of planning team agreement required under 7 AAC 130.218. This process was improper. If SDS believed the requested services were not supported, the amendment should have been returned to the planning team for revision and resubmission through the required person-centered process.

Under 7 AAC 130.217(b), the Department may only approve a support plan if it determines that the plan satisfies the criteria in that subsection, including that the services cannot be provided under 7 AAC 105–7 AAC 160 except as waiver services. That responsibility cannot be carried out effectively if the amendment request does not clearly identify the services being requested, such as additional support for skilled medical interventions rather than additional support for ADLs, IADLs, and habilitative goals and objectives. Thus, while the Division bears a statutory and regulatory obligation to assess duplication and sufficiency, that determination was not flawed here because the amendment failed to articulate the true reason for the amendment request and how the additional services would address the change of circumstances related to the health, safety, and welfare of the recipient. This breakdown in the process

[5] Exhibit F, p. 29–40.
[6] Exhibit F, p. 40.

underscores why the Division's partial approval cannot be affirmed and underscores the need for the request to return to the care planning team for further development.

SDS correctly recognized based on the documentation submitted with the amendment that the additional acuity services actually requested—framed around additional support for ADLs, IADLs, and habilitative—were duplicative, unnecessary, and unsupported. However, SDS reached that conclusion and altered the plan outside the required person-centered process. SDS's partial approval therefore did not, and could not, address the true change in circumstances, which was not accurately represented in the amendment request. By bypassing the planning team process, SDS denied the recipient full participation and undermined the regulatory requirements of 7 AAC 130.217 and 7 AAC 130.218. This deficiency supports the reversal of SDS's partial approval and return of the matter to the planning team for further development in accordance with the regulations.

C. Acuity Add-On Eligibility under 7 AAC 130.267 and Medical Evidence

Under 7 AAC 130.267(a), the Department may only authorize acuity payments for recipients receiving either Residential Supported-Living services under 7 AAC 130.255, assigned procedure code T2031, or Group-Home Habilitation services under 7 AAC 130.265(f), assigned procedure code T2016, as referenced in 7 AAC 145.520(h). The record establishes that the recipient receives Family Home Habilitation services, procedure code S5145, and does not receive services under either of the codes identified in 7 AAC 145.520(h). As a matter of regulation, therefore, acuity payments cannot be authorized for the recipient's current service configuration.

Because this threshold eligibility requirement is not satisfied, the proposed decision's conclusion that there was a "dearth of medical evidence" showing the recipient required one-to-one services under 7 AAC 130.267(b)(2) was unnecessary to the disposition of this case. The Department must first determine whether acuity services are available under the regulation and whether the services requested in the amended support plan would be duplicative of services available under 7 AAC 105–160 before reaching questions of documentation or sufficiency.

Even if the analysis proceeded to subsection (b), this decision maker finds that the proposed decision's reasoning misstates the regulatory requirement. Contrary to the impression that physician testimony is necessary, 7 AAC 130.267(c)–(d) requires documentary support, such as recent assessments, hospitalizations, daily activity records, or treatment management notes, but does not mandate live testimony from a medical provider. In another case referenced in the proposed decision, testimony from a medical provider was presented and relied upon, but that reflected the evidence available in that record. It should not be read as establishing an additional regulatory requirement, only as one possible means of satisfying it. The evidentiary requirements are expressly set out in the regulation: subsection (c) requires written documentation describing how the condition justifies one-to-one support, what interventions have been attempted, consistency with the support plan, and how the services would improve management; subsection (d) then requires supporting evidence including the most recent medical evaluation, records of recent hospitalizations or interventions, 30 days of clinical activity logs, and a description of how medications and treatments are managed. A provider's testimony may supplement the evidentiary requirements or help demonstrate compliance, but direct testimony is not required.

The record in this case contains multiple treatment notes confirming the recipient's need for skilled interventions. A swallow study dated July 18, 2024, found that "no safe consistency or modality is found today. Aspiration risk."[7] Skilled nursing notes document suctioning due to difficulty clearing

[7] Exhibit G, p. 26 (Swallow Study dated July 18, 2024).

secretions, intermittent oxygen desaturation, and ongoing assistance with airway management including repositioning, chest physiotherapy, medications, and suctioning. For example, on February 28, 2025, Maxim staff recorded: "Patient requires frequent repositioning, CPT, medications and suctioning due to difficulty clearing secretions and intermittent drop in oxygen saturations."[8] March 2025 notes then repeatedly document suctioning and airway interventions.[9] ISP data collection from February 19, 2025, records that "he had to be vented,"[10] while March 14, 2025, notes report "suctioned… high risk of airway compromise."[11]

Although these records demonstrate the complexity of the recipient's medical needs and might have supported the evidentiary requirements of 7 AAC 130.267(c)–(d) had the prerequisite criteria been met, the amendment request fails on other grounds as explained above.

D. Conclusion

For these reasons, SDS's partial approval of the May 2025 support plan amendment is REVERSED. The previously authorized support plan remains in effect. If the recipient's care planning team believes additional services are necessary for reasons other than those outlined in the May amendment request, as the guardian's testimony suggests, and outside of acuity given the limitation in 7 AAC 130.267(a), they may submit a new request for additional services through the person-centered planning process. In doing so, the care planning team in encouraged to review this decision, consult with the recipient and guardian regarding the testimony provided in this case, and consider which combination of Medicaid State Plan and Home and Community-Based Waiver services is medically necessary and sufficient to maintain the recipient in the community.

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 29th day of September, 2025.

Signed
Daniel R. Phelps II
Process Improvement Manager
Office of the Commissioner
Alaska Department of Health

8 Exhibit G, p. 31 (Maxim Nursing Note dated Feb. 28, 2025).
9 Exhibit G, pp. 326, 330, 361, 373 (Maxim Nursing Notes, March 2025).
10 Exhibit G, p. 282 (Therap ISP Data Collection, Feb. 19, 2025).
11 Exhibit G, p. 315 (Nursing Note dated Mar. 14, 2025).

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

In the Matter of	)	
	)	
K. H.	)	OAH No. 25-1779-MDS
	)	Agency No.

DECISION

I. Introduction

K. H. is a severely disabled Medicaid Home and Community-Based Waiver (Waiver) recipient. He filed an amended Person Centered Support Plan (PCSP) with the Division of Senior and Disabilities Services, which requested that he receive the Acuity payment rate for 8 hours per day. The Division denied that request. Mr. H. requested a hearing to challenge that denial.

Mr. H.'s hearing was held on July 24, 2025. Mr. H., who is a disabled minor, was represented by E. X., his court-appointed guardian. She testified on his behalf, as did N. J., his Medicaid Care Coordinator. Victoria Cobo-George, a Division Fair Hearing representative, represented the Division. Tammy Smith, a Division Health Program Manager, testified for the Division, as did Moli Atanoa, a Division nursing unit supervisor.

The evidence in this case shows that Mr. H. is disabled and completely dependent upon others for all his care needs, which are extensive and ongoing. However, despite the complexity of his condition and the attendant care needs, those needs do not rise to the level of him requiring dedicated one-on-one support. The Division's denial of his request for an acuity payment rate is AFFIRMED.

II. Facts

Mr. H. is currently 16 years old. He receives Medicaid Waiver services. Those services consist of family home habilitation services, respite services, nursing oversight and care management services, and day habilitation services.[1] Mr. H. also receives personal care services for 14 hours per week,[2] and private duty nursing services, which are approved for between 96 to

[1] Ex. E, p. 1.
[2] Ex. D, p. 8.

102 hours weekly.[3] However, because of staffing issues with the nursing agency, the most he has been receiving is 80 hours per week of nursing services.[4]

Ms. X. and her husband are Mr. H.'s court-appointed guardians. They have been caring for him since he was an infant. He resides in the X.'s home, where Ms. X is his authorized family home habilitation service provider. His younger brother, who shares his diagnosis, shares a bedroom. There are three other disabled persons in the home, in addition to Mr. H. and his brother.[5]

Mr. H. applied to amend his PCSP to add eight hours per day of an acuity rate.[6] During the application process, Mr. H. supplied copious documentation of his day to day care and his medical care.[7] The Division denied the amendment request on May 22, 2025, stating that the submitted documentation did not support a showing that Mr. H. did not meet the requirements for an acuity rate.[8]

Mr. H. is diagnosed with Allan-Herndon-Dudley Syndrome:

> His syndrome is similar to a child with spastic quadriplegic cerebral palsy, dystonic rigidity and high risk for pressure sores. He is considered to have severely limited mobility. He is incontinent, both bowel and bladder. He is fully reliant on his caregivers for all of his daily cares including regular rolling, repositioning, toileting/incontinence and enteral feeding. He has dysphagia requiring a G tube for all of his feeds and raising the head of his bed is necessary to reduce risk of aspiration. He does choke and gags on his secretions, requiring intermittent suctioning. He requires chest percussive therapy to clear his pulmonary secretions throughout the day. He has previously been hospitalized for feeding intolerance. He requires position changes at least every 2 hours. However, if he is experiencing episodes of discomfort/spasticity, he may require much more frequent care, stretching, and cares.
>
> He is nonverbal and assessing discomfort is very challenging so any possible efforts to reduce his discomfort are necessary. As he has grown, it has become more and more difficult to attend to his needs, particularly with repositioning while in bed, dealing with incontinence, airway management and transfers.[9]

---

3 Ex. E, p. 34.
4 Ex. E, pp. 10, 13, 15; Ms. X.'s testimony.
5 Ex. E, p. 10; Ms. X.'s testimony.
6 Ex. E.
7 The record in this case, not including the additional documents provided by Mr. H. shortly before hearing consisted of over 1300 pages.
8 Ex. D.
9 Ex. E, p. 58.

Both his physician and his physical therapist opine that he requires a two-person assist for transfers and other activities of daily living.[10] His physical therapist provided a written statement that specifically noted that Mr. H. required a two-person assist because he

> exhibits unpredictable fluctuations in muscle tone, including episodes of increased rigidity and involuntary movements. These episodes make transfers inherently unsafe with a single caregiver, as they can lead to sudden shifts in body weight, loss of balance, and increased risk of injury to both the patient and caregiver.[11]

The physical therapist's statement further explained that the need for a two person assist involved transfers to a wheelchair, to a floor matt, transfers using his Hoyer lift, transfers for bathing, and to keep him stable while being fed and provided liquids through his G-tube.[12] The statement concluded that "[a]ttempting transfers or activities of daily living with only one caregiver presents a substantial risk of falls, injury, and inadequate care. Therefore, I strongly recommend that all transfers, feeding, and bathing activities be performed with two-person assistance at all times."[13] Mr. H. also has a seizure disorder, which is currently under control.[14]

Mr. H., due to his multiple impairments, requires constant care. Because Mr. X. works out of town, he cannot assist Ms. X. a great deal of the time. Ms. X. does have assistance from Mr. H.'s other service providers and a neighbor who can sometimes assist her on a voluntary basis. However, despite these other resources, she is often the only caregiver available to care for Mr. H. Ms. X., who is 64 years old, cannot safely assist Mr. H. with his activities of daily living by herself. She is paying out of her own pocket for someone to assist with his care 24 hours per week. Further, because she has several other disabled children in the home, she cannot always interrupt their care to immediately attend to Mr. H. She described that he is at risk of aspiration, requires suctioning approximately 6 times daily, and will have dystonic "arcing" episodes during his sleep between 1 to 4 times nightly that require intervention. She gets very little sleep because of her constant monitoring.[15]

Ms. J. described Mr. H.'s head "collapsing" onto his chest, which makes him unable to breathe, and requires that his head be lifted so that he can breathe.[16] Ms. X. testified similarly

---

10 Ex. E, pp. 58 – 60.
11 Ex. E, p. 59.
12 Ex. E, pp. 59 – 60.
13 Ex. E, p. 60.
14 Ms. X.'s testimony; Ex. E, pp. 51.
15 Ms. X.'s testimony.
16 Ms. J.'s testimony.

and stated Mr. H. has difficulty breathing. She stated that he cannot be left alone at any time, even while in bed, because of his breathing issues.[17]

III. Discussion

A. Medicaid Waiver Services Overview

The Medicaid Home and Community-Based Waiver Services program was created by Congress to allow states to offer long-term care, not otherwise available through the states' Medicaid programs, to eligible individuals in their own homes and communities instead of in skilled nursing facilities or hospitals.[18] To obtain approval from the federal Centers for Medicare & Medicaid Services (CMS) for a home and community-based care waiver program, the state seeking the waiver must demonstrate that its average per capita expenditures for persons receiving benefits under the waiver do not exceed the average estimated per capita cost of providing Medicaid services to the same group of individuals in an institutional setting.[19] The impact of the program's cost neutrality provision is that waiver services are not required to be the best possible treatment and services to recipients, but only those services, costing no more than

---

17 Ms. X.'s testimony.

18 *See* 42 U.S.C. § 1396n(c)(1); 42 C.F.R. §§ 435.217; 441.300-310. 42 C.F.R. § 440.180, "Home and community-based waiver services" provides in relevant part:

> (a) Description and requirements for services. "Home or community-based services" means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this chapter.
>
> (1) These services may consist of any or all of the services listed in paragraph (b) of this section, as those services are defined by the agency and approved by CMS.
>
> (2) The services must meet the standards specified in § 441.302(a) of this chapter concerning health and welfare assurances.
>
> (3) The services are subject to the limits on FFP described in § 441.310 of this chapter.
>
> (b) Included services. Home or community-based services may include the following services, as they are defined by the agency and approved by CMS:
>
> (1) Case management services.
>
> (2) Homemaker services.
>
> (3) Home health aide services.
>
> (4) Personal care services.
>
> (5) Adult day health services.
>
> (6) Habilitation services.
>
> (7) Respite care services.
>
> (8) Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness, subject to the conditions specified in paragraph (d) of this section.
>
> (9) Other services requested by the agency and approved by CMS as *cost effective and necessary to avoid institutionalization*. [Emphasis added.]

19 See 42 U.S.C § 1396n(c)(2)(D).

institutional care, that are necessary to avoid institutionalization.[20] In doing so, however, a state "may not arbitrarily deny or reduce the amount, duration, or scope of a required service . . . to an otherwise eligible recipient solely because of the diagnosis, type of illness or condition."[21]

Alaska participates in the Medicaid Home and Community-Based Waiver Services program.[22] Each service must be approved as a part of a recipient's PCSP (also referred to as a plan of care or a support plan).[23] Specifically, 7 AAC 130.217(b) provides that the Department of Health will approve a support plan if the Department determines that:

> (1) the services specified in the support plan are *sufficient to prevent institutionalization and to maintain the recipient in the community* [Emphasis added.];
> (2) each service listed on the support plan
>
> (A) is of sufficient amount, duration, and scope to meet the needs of the recipient;
>
> (B) is supported by the documentation required in this section; and
>
> (C) cannot be provided under 7 AAC 105 - 7 AAC 160, except as a home and community-based waiver service under this chapter; and
>
> (3) if nursing oversight and care management services are to be provided, a nursing plan in accordance with 7 AAC 130.235 is included.

The regulation governing Alaska's provision of an "acuity rate" or "acuity payment" is found at 7 AAC 130.267, which provides in pertinent part:

> (a) The department will pay for additional services under this section that
>
> (1) are provided for a recipient who is qualified under (b) of this section and is receiving

---

[20] See generally, *Alexander v. Choate*, 469 US 287, 303, (1985) (Medicaid only assures that individuals will receive adequate health care, not care tailored to their particular needs). However, the Alaska Supreme Court, in *Garner v. State Dep't of Health*, 63 P. 3d 264, 270 (2003) cited *Alexander* for the rule that "where a service or benefit is defined in such a way as to deny an otherwise eligible disabled individual from gaining meaningful access to it, that individual has suffered discrimination as defined by the ADA." *Garner,* 63 P.3d at 270, citing *Alexander v. Choate*, 469 U.S. at 301.

[21] 42 C.F.R. § 440.230(c).

[22] AS 47.07.045 provides

> (a) The department may provide home and community-based services under a waiver in accordance with 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act), this chapter, and regulations adopted under this chapter, if the department has received approval from the federal government and the department has appropriations allocated for the purpose. To supplement the standards in (b) of this section, the department shall establish in regulation additional standards for eligibility and payment for the services.

[23] 7 AAC 130.209, 7 AAC 120.217.

> (A) residential supported-living services under 7 AAC 130.255 . . .; or
>
> (B) group-home habilitation services under 7 AAC 130.265(f) . . .;
>
> (2) are requested in accordance with (c) of this section;
>
> (3) the department determines to be necessary, based upon evaluation of the supporting documentation submitted in accordance with (d) or (e) of this section; and
>
> (4) receive prior authorization.
>
> (b) For purposes of this section, a qualified recipient is one that
>
> (1) needs services that exceed those authorized in the recipient's current support plan . . . and
>
> (2) because of the recipient's physical condition or behavior, needs *direct one-to-one support from direct care workers whose time is dedicated solely to providing services under (a)(1) of this section to that one recipient 24 hours per day, seven days per week, in all environments in which the recipient functions*. [Emphasis added.]

Further subsections describe the documentation that must be submitted with a request for the acuity payment,[24] including written documentation that[25]

> (A) describes how the recipient's physical condition or behavior justifies the support described in (b) of this section;
>
> (B) lists each intervention tried or in use to address the recipient's physical condition or behavior, and whether the intervention was successful or unsuccessful;
>
> (C) indicates how additional services under this section would be consistent with services approved as part of the recipient's support plan under 7 AAC 130.217 and 7 AAC 130.218; and
>
> (D) addresses how the acuity payment under this section would be used to improve management of the recipient's physical condition or behavior; . . .

B. Burden of proof and standard of review.

Mr. H. is requesting additional services under his PCSP. He therefore has the burden of proof by a preponderance of the evidence.[26]

The standard of review to be applied in this proceeding is *de novo* review, as to both law and facts.[27] Some evidence presented in this case, principally the testimony of Ms. X. and Ms. J.,

---

24 7 AAC 130.267(c)-(e).

25 7 AAC 130.267(c)(1).

26 7 AAC 49.135.

27 *See* 42 C.F.R. 431.233(a); 431.244(e); 7 AAC 49.170. *See also* Albert S. v. Dept. of Health and Mental Hygiene, 891 A.2d 402 (2006); Maryland Dept. of Health and Mental Hygiene v. Brown, 935 A.2d 1128 (Md. App. 2007); In re Parker, 969 A.2d 322 (N.H. 2009); Murphy v. Curtis, 930 N.E.2d 1228 (Ind. App. 2010).

was not available to the Division's reviewers. The administrative law judge may independently weigh the evidence and reach a different conclusion, even if the original Division decision had a reasonable basis in law and was factually supported. Similarly, the Commissioner is not required to give deference to factual determinations or legal interpretations of departmental staff. [28]

C. 7 AAC 130.267(b)(2) requires dedicated services solely for the recipient.

Multiple decisions have made clear that if a risk is foreseeable, would require immediate attention, and that immediate response is only possible with dedicated care, the actual care provided does not need to be continuous.[29] In *In re KE,* KE had had seizures and limitations that placed him at high risk of a fall and severe injury should he try and ambulate independently. However, Mr. E was unable to understand this risk and remain in bed or his wheelchair. The Commissioner approved acuity, finding "that he needs one-on-one supervision, so that assistance with transfers and ambulation is *immediately available when he needs it*."[30] That decision also held that because Mr. E resided "in a two-person group home, it is not always possible to provide him with that continuous observation and assistance without him having a dedicated attendant." In the most recent Commissioner level decision dealing with an acuity rate request, OAH Case No. 24-0268-MDS, the recipient was approved for acuity rate because she was at a foreseeable risk of asphyxiation and anoxia if she did not have immediate care. In that case, the recipient had the benefit of testimony from her medical provider.[31]

The evidence in this case shows that Mr. H. has very intensive care needs that Ms. X. and multiple others attend to. He is entirely dependent upon others for all his care. He must be suctioned intermittently. He must be repositioned frequently. His transfers and other activities of daily living require two people to perform them safely, due not only to his physical size but his involuntary unpredictable body movements. However, unlike the recipient in 24-0268-MDS, who was able to have her medical provider testify, there is a dearth of medical evidence showing that Mr. H.'s foreseeable care needs are so severe and unpredictable that he requires care that is "*immediately available when he*

---

[28] *In re L.D.,* OAH Case No. 18-0011-MDS (Commissioner of Health and Social Services 2018)(available at https://aws.state.ak.us/OAH/Decision/Display?rec=3014).

[29] *See* OAH Case No. 24-0407-MDS (Commissioner of Health 2025) (unpredictable need for immediate suctioning due to potential for aspiration and pneumonia). *See also In re CU,* OAH Case No. 19-0252-MDS(Commissioner of Health and Soc. Serv. 2019)(available at https://aws.state.ak.us/OAH/Decision/Display?rec=6525) (self-injurious behaviors). OAH Case No. 17-0217-MDS, *Decision on Remand*, (Commissioner of Health and Soc. Serv 2017). *In re KE,* OAH Case No. 16-0117-MDS (Commissioner of Health and Soc. Serv. 2016) (available at https://aws.state.ak.us/OAH/Decision/Display?rec=2820)

[30] *In re KE,* OAH Case No. 16-0117-MDS (Commissioner of Health and Soc. Serv. 2016) (available at https://aws.state.ak.us/OAH/Decision/Display?rec=2820)

[31] OAH Case No. 24-0268-MDS, Decision on Remand (Commissioner of Health 2025).

needs it" and that this care cannot be provided without a dedicated provider.[32] Mr. H. requires suctioning for secretions. Ms. X. and Ms. J. testified regarding Mr. H.'s head collapsing onto his chest. Mr. H.'s doctor's letter refers to him needing airway management. However, there is no medical evidence showing an unpredictable immediate need for for suctioning, airway management, or other care, which can only be supplied by a dedicated provider.

As a result, the record in this case does not demonstrate, as required by 7 AAC 130.217(b), that Mr. H. meets the regulatory requirement, per 7 AAC 130.267(b)(2), to qualify for the acuity payment rate.

IV. Conclusion

Mr. H. had the burden of proof in this case to demonstrate that he qualified for the acuity payment rate. Although the evidence shows that he has exceedingly extensive care needs, he did not meet that burden. The Division's denial of his request for an acuity payment rate is AFFIRMED.

Dated: August 13, 2025

By: *Signed*
Signature
Larry Pederson
Name
Administrative Law Judge
Title

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

[32] *In re KE,* OAH Case No. 16-0117-MDS (Commissioner of Health and Soc. Serv. 2016) (available at https://aws.state.ak.us/OAH/Decision/Display?rec=2820)