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

In the Matter of	)	
	)	
M. X.	)	OAH No. 25-0308-MDS
	)	

DECISION[1]

I. Introduction

M. X. is a Medicaid Waiver recipient who applied to renew his Medicaid Waiver Person Centered Support Plan (PCSP). The Division of Senior and Disabilities Services (Division) partially denied that renewal, providing him with 12 hours per week (2496 units) of day habilitation services instead of the requested 20 hours per week (4160 units) he had received in the prior plan year.

The evidence in this case showed that 20 hours of day habilitation is necessary for Mr. X., because of a critical need, to prevent the risk of institutionalization or incarceration. Accordingly, the Division's reduction in Mr. X.'s day habilitation services from 20 hours per week to 12 hours per week is **REVERSED**.

II. Facts

A. Procedural History

Mr. X. is a Medicaid Waiver recipient who receives day habilitation services. He was approved for 4160 units (20 hours per week) of day habilitation services for his PCSP for the year beginning February 21, 2024, and ending on February 20, 2025.[2] Mr. X. applied to renew his PCSP on December 17, 2024 for the year beginning February 21, 2025 through February 20, 2026.[3] In his renewal request, he requested that he continue to receive the same level of day habilitation services – 4160 units.[4]

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1 A proposed decision was issued in this matter October 20, 2025, the parties were provided the opportunity to file proposals for action, and this final decision now issues. The final decisionmaker, pursuant to AS 44.64.060(e), modified one sentence of this decision. The modification changed "clear and convincing evidence is required to reject a treating physician's opinion" to "clear and convincing reasons are required to reject a treating physician's opinion." That change is reflected on page seven.

2 Ex. F, p. 2.

3 Ex. G.

4 Ex. E.

The Division, after reviewing his renewal application, partially denied his request for day habilitation services, approving 2496 units (12 hours per week) for the upcoming plan year, stating:

> Effective July 1, 2024, the regulatory requirement for Day Habilitation services changed to state that any Service Plan that had a start date on or after 7/1/2024 would be held to a regulatory limit of Day Habilitation services of 12 hours per week. Under 7 AAC 130.260 (c), the department will only pay for a maximum of 624 hours each year, or 12 hours per week, of Day Habilitation services. The department may approve a limited amount of additional Day Habilitation services if the recipient's current physical or behavioral condition places the recipient at risk of institutionalization or incarceration if additional Day Habilitation services are not provided.[5]

While Mr. X.'s PCSP argued the extra hours were needed to provide "an active lifestyle rich in activities that allow him to expend energy through … physical exertion," and were necessary to "keep him safe, to remain an active member of his community, and to avoid institutionalization."[6] The Division found the support plan did not adequately document the "critical need." Specifically, the Division noted that the plan did not "outline any critical behaviors that could put M. at risk of causing physical harm to himself or others during the previous year," nor did it explain "how M.' behaviors could only be mitigated by the additional 8 hours per week of Day Habilitation."[7] Ultimately, the Division determined that the approved services—12 hours of Day Habilitation, 20 hours of Supported Living, 10 hours of Hourly Respite, and 14 days of Daily Respite— were sufficient to prevent institutionalization and maintain Mr. X. in the community. Mr. X.'s parents and legal guardians, C. and K. X., requested a hearing to challenge the reduction of Mr. X.'s day habilitation services and the matter was referred to the Office of Administrative Hearings (OAH).

On February 19, 2025, the Division moved for summary adjudication arguing that there has been a change in the law limiting day habilitation services to 624 hours per calendar year and that "[t]here is a new process in 7 AAC 130.260(c) to apply for a 'limited amount' of additional service in a few specific circumstances. If the recipient believes they meet these circumstances, they may apply for them at any time."[8] As this case involves a reduction in services, and a great

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5 Ex. D.
6 Ex. G.
7 Ex. D.
8 Ex. H. By way of explanation, in its denial, and early on in this case, the Division ascribed the burden of proof to Mr. X.. As will be explained in more detail below, the Division is the party with the burden of proof.

deal of facts were in dispute, the Division's motion for summary adjudication was denied. After the Division's motion was denied, the parties engaged in extensive mediation. When that mediation was unsuccessful, the matter was scheduled for a hearing.

The hearing in this matter was held on September 3, 2025. Mr. X. was represented by his attorney, Mark Regan. Mr. Regan presented testimony from C. and K. X., Mr. X.'s Medicaid Care Coordinator J. Z., and U. N., the senior and disability services program director with Community Connections.

Paul Peterson, an assistant attorney general, represented the Division. Mr. Peterson presented testimony from Judson Olibrice, the Division's reviewer in this case.

B. Relevant Facts

Mr. X. is a 31-year-old man with a primary diagnosis of autism spectrum disorder Level 3.[9] He is largely non-verbal, communicating with single words, short phrases from movies, or vocalizations. When he is frustrated, or his routine is changed, these vocalizations can be concerning to others in the community. Mr. X. lives at home with his parents, C. and K. X. Mr. X. has a "history of physical agitation since puberty and can become aggressive when his routines are changed."[10] These behaviors include hitting himself and others, yelling, hitting his head against surfaces, pinching, slapping, and throwing objects. Those behaviors are exacerbated by stress and changes in routine, such as when there are staff changes or he is unable to go to the pool for more than a few days in a row.[11]

In February and March of 2017, Mr. X.'s behavior severely decompensated. He became significantly more aggressive and destructive, repeatedly striking his head against walls and glass, throwing objects, and slamming his head on a care provider's car. In slamming his head against the car Mr. X. "split his head open."[12] During this period, his "rages" would last hours.[13] On March 4, 2017, his attempts to harm himself or others escalated to the point that his family had to physically restrain him to prevent Mr. X. from slamming his head into a mirror and injuring himself.[14] During this incident, Mr. X. bit his brother, he also hit his mother and brother

9 Ex. 2. *See also* Ex. E.
10 Ex. 2. *See also* Ex. G.
11 Ex. 2. *See also* Testimony of Mrs. X.
12 Testimony of Mrs. X.
13 Testimony of Mrs. X.
14 Testimony of Mrs. X.

hard enough to cause bruising.[15] With no other option, his mother called the police. Apparently unfamiliar with Mr. X.'s limitations, the police attempted to speak directly with him. Those attempts to communicate were unsuccessful and Mr. X. was handcuffed. Mr. X. was transported in the back of the police cruiser to the hospital, where he was placed on a 72-hour psychiatric hold.[16]

Following this hospitalization, Mr. X.'s treatment plan changed significantly. He was prescribed Risperidone to help manage his aggression and, eventually, began a new routine that included swimming a mile every day. This combination of medication and intensive physical activity resulted in a significant decrease in violent and self-harming behaviors, though it has not eliminated them entirely.[17]

Currently, Mr. X. still exhibits instances of physical aggression, including hitting, slapping, and pinching. Most recently, in late August of 2025, Mr. X. hit his father while they were traveling in the family's boat.[18] However, these behaviors have become his baseline and have not resulted in further critical incident reports or hospitalizations. Because Mr. X. is a large individual, this baseline aggression has made it difficult to retain consistent staff.[19] Mr. X. has been able to maintain his current care provider, C., because he is a "big guy and there have been times where M.'s been aggressive with C., but C.'s kind of just big enough to take it, frankly, and … other people … weren't able to kind of make it through those challenging behaviors to stay with them more long-term."[20]

His day habilitation activities are focused on community integration and exercise including going to grocery stores, folding boxes, fishing, and, most importantly, swimming. His goals include learning community safety skills, social interaction, and getting at least 60 minutes of physical activity daily.[21] Swimming is the only form of exercise Mr. X. will engage in consistently enough to meet this goal. Swimming offers a full-body workout using all of his gross motor skills; as a result, it is very effective in regulating his emotional or behavioral

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15 Testimony of Mrs. X.
16 Testimony of Mrs. X.
17 Testimony of Mrs. X.; Ms. Z.; and Mr. N. *See also* Ex. G.
18 Testimony of Mrs. X.. Thankfully, this incident caused no injury. However, aggression on a small boat navigating in southeast Alaska is inherently dangerous, as it could interfere with the vessel's safe operation.
19 Testimony of Mr. N.
20 Testimony of Mr. N..
21 Ex. E.

issues.[22] The record shows that when he is unable to engage in his day habilitation activities for extended periods, particularly swimming, his negative behaviors increase. In one example, during a family trip to Wisconsin, Mr. X. was without his swimming routine for approximately 10 days. Mr. X.'s behavior worsened to the point where he was escorted through the airport, arm-in-arm. Even with this level of restraint, Mr. X.'s behavior and vocalizations were still enough to result in a mild police contact.[23]

Dr. W. D., Mr. X.'s psychiatrist for the past seven years, submitted a letter stressing the critical need for Mr. X.'s current level of services. Dr. D. stated that Mr. X. "can become aggressive when his routines are changed," has "only very limited control of his impulsivity," and "requires substantial supported living services to keep him out of legal involvement with the police." It is Dr. D.'s uncontradicted medical opinion that without his current level of support, "M. is at risk for either legal involvement with the police and jail or institutionalization." Dr. D.'s letter also explained that swimming is "**medically necessary**" to counteract the risk of "metabolic syndrome (diabetes, hyperlipidemia)" caused by his essential medications. Based on this, Dr. D. concluded, in bold, that "**M. requires at least 20 hours of Day Habilitation support a week**."[24] Mr. X. has received 20 hours of day habilitation per week since at least 2017.

III. Discussion

A. The Regulation

Day habilitation services are provided to qualified Medicaid Waiver recipients for "active teaching or training based on goals that are meaningful to the recipient, outcome-based, and have the explicit purpose of developing or retaining skills and functioning reasonably necessary for community integration."[25] Day habilitation services are normally limited to a total of 624 hours per year. However, the Department may approve a limited amount of additional day habilitation services if the criteria of 7 AAC 130.260(c) are satisfied.[26]

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22 Testimony of Ms. Z. *See also* Testimony of Mrs. X.
23 Testimony of Mrs. X.
24 Ex. 2 (emphasis in the original).
25 7 AAC 130.260(b)(6)(A).
26 7 AAC 130.260(c).

The pertinent regulation, 7 AAC 130.260(c), was last amended as of October 2020. It contains a soft regulatory cap of 624 hours per year and contains a comprehensive description of the requirements for exceeding that cap:

> The department will only pay for a maximum of 624 hours each year of all types of day habilitation services from all providers combined. The department may approve a limited amount of additional day habilitation services if
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> (1) the department finds that (A) the recipient's current physical or behavioral condition places the recipient at risk of institutionalization or incarceration if additional day habilitation services are not provided; (B) the recipient's support plan and records indicate that the recipient has a critical need for additional day habilitation services because of one or more of the following: (i) the recipient has an acute or degenerative physical condition that necessitates participation in activities to maintain or improve that condition that are available only in the community; (ii) the recipient exhibits behaviors that create a risk of physical harm to the recipient or others that can only be mitigated by the development of skills related to appropriate behavior in the community; (iii) the recipient's one-to-one support provided under 7 AAC 130.267 was recently terminated, and the recipient needs to learn skills required for living successfully in the community; or (iv) the recipient's release from an intermediate care facility for individuals with intellectual disabilities or the criminal justice system within the current or prior support plan year increases the need for additional day habilitation services for teaching or training skills for community integration; and (C) the recipient's medical, social, educational, or other records support the recipient's need for, and capacity to engage in and benefit from, additional active teaching or training; those records include the following: (i) the current and prior year assessments under 7 AAC 130.213; (ii) the current and prior year support plans; (iii) records maintained under 7 AAC 105.230(d); (iv) direct service case notes;
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> (2) the request for additional day habilitation services is submitted in a recipient's support plan that (A) describes how the recipient's physical or behavioral condition and one or more of the circumstances in (1)(B) of this subsection justify additional services; (B) identifies goals related to the skills specified in (b)(3) of this section and explains why additional services in a day habilitation setting are necessary to reach the recipient's goals; (C) lists interventions used or in use to address the recipient's condition and whether each intervention was successful or unsuccessful; and (D) indicates how additional day habilitation services will not duplicate or supplant other services rendered to the recipient.[27]

The Division delayed implementation of the 2020 version of the regulation until July 1, 2024, due to the Covid-19 pandemic. The term "risk of institutionalization" is defined by regulation as follows:

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[27] 7 AAC 130.260(c).

> "risk of institutionalization" means it is likely that the recipient's current condition would require the recipient to be relocated, within the support plan year, from the recipient's current residence to an acute care hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities.[28]

This case represents the first application of the current regulation to Mr. X.'s PCSP.

B. Burden of Proof

Under 7 AAC 49.135, in cases where the Division's action involves a reduction of benefits, the Division bears the burden of proving by a preponderance of the evidence that its reduction was correct.[29] In order to do this, the Division must prove that, for the hours above the soft cap, the requirements of 7 AAC 130.260 were not met and, therefore, Mr. X. no longer qualifies for a limited amount of additional day habilitation services.

C. Medical Evidence

In regard to medical evidence, a long line of federal case law interpreting the Medicaid statute and regulations creates a presumption in favor of the medical judgment of the treating physician in determining medical necessity.[30] For this reason, more weight is given to a treating physician's opinion than to the opinions of those who do not treat a claimant.[31] If uncontradicted by another doctor, clear and convincing reasons are required to reject a treating physician's opinion.[32] Even when a treating physician's opinion is contradicted by another physician, that opinion "can only be rejected for specific and legitimate reasons that are supported by substantial evidence in the record."[33] The opinion of a non-examining physician alone cannot constitute

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28 7 AAC 130.319(20).

29 7 AAC 49.135.

30 *Weaver v. Reagen,* 886 F.2d 194, 200 (8th Cir. 1989). *See also* S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S.C.C.A.N. 1943, 1986, ("the physician is to be the key figure in determining utilization of health services").

31 *Lester v. Chater,* 81 F.2d 821, 830 (9th Cir. 1996) (holding an examining physician's opinion is "entitled to greater weight than the opinion of a non-examining physician."). Although *Lester* was decided in the context of Social Security benefits, the same principle is applied in Medicaid cases. *See, e.g., Winans v. Bowen,* 853 F.2d 643, 647 (9th Cir. 1987).

32 *Lester* at 830. *See, e.g.*, *Baxter v. Sullivan,* 923 F.2d 1391, 1396 (9th Cir. 1991) (where the treating doctor's opinion is not contradicted by another doctor, it may be rejected only for "clear and convincing" reasons); *Embrey v. Bowen,* 849 F.2d 418, 422 (9th Cir. 1988) ("clear and convincing" reasons are required to reject the treating doctor's ultimate conclusions).

33 *Lester* at 830-831 (even if the treating doctor's opinion is contradicted by another doctor, this opinion may not be rejected without providing "specific and legitimate reasons" supported by substantial evidence in the record for so doing, citing *Murray v. Heckler,* 722 F.2d 499, 502 (9th Cir. 1983)).

substantial evidence that justifies the rejection of the opinion of either an examining physician *or* a treating physician.[34]

Dr. W. D. has been Mr. X.'s psychiatrist since October 2018. In a signed letter Dr. D. noted that Mr. X. "can become aggressive when his routines are changed" he has "only very limited control of his impulsivity" and "can respond aggressively when frustrated."[35] Further, Dr. D. opined that Mr. X. "requires substantial supported living services to keep him out of legal involvement with the police and preserve safety not only for M., but those around him."[36] It is Dr. D.'s medical opinion that without these services "M. is at risk for either legal involvement with the police and jail or institutionalization where, as a nonverbal person with autism, he absolutely does not belong."[37] Dr. D. concluded, in bold, that "**M. requires at least 20 hours of Day Habilitation support a week.**" Dr. D. also explained that Mr. X.'s mood stabilizers place him at increased "risk for metabolic syndrome (diabetes, hyperlipidemia). As such, access to swimming at the Recreation Center is **medically necessary** to control his weight, glucose, and cholesterol."[38] Crucially, Dr. D. has only been Mr. X.'s psychiatrist since *after* he was placed on Risperidone. As a result, his medical opinion about Mr. X.'s behaviors, his risk of institutionalization, and his need for day habilitation and swimming is based on his evaluation of Mr. X. *after* that change and the related reduction in the frequency of aggressive behaviors. In this case, there is no medical evidence to contradict Dr. D.'s medical opinion.

D. Analysis

The Division bears the burden of proving by a preponderance of the evidence that its reduction of Mr. X.'s benefits was correct. To do so, the Division must show that Mr. X. no longer meets the regulatory requirements in 7 AAC 130.260(c) to receive day habilitation services above the 12-hour-per-week soft cap. The Division has not met this burden.

1. Mr. X. is at Risk of Institutionalization or Incarceration

Under 7 AAC 130.260(c)(1)(A), a recipient may qualify for additional hours if their current behavioral or health condition places them at risk of institutionalization or incarceration. While swimming is medically necessary to counteract the increased risk of weight gain and

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[34] *Lester* at 831, *citing Pitzer v. Sullivan,* 908 F.2d 502, 506 n.4 (9th Cir. 1990); *Gallant v. Heckler,* 753 F.2d 1450, 1456 (9th Cir. 1984).
[35] Ex. 2.
[36] Ex. 2.
[37] Ex. 2.
[38] Ex. 2 (whole paragraph).

diabetes that come with his mood stabilization medication, even significant weight gain would not necessarily require acute-care hospitalization within the plan year. Mr. X.'s behavior issues are of far more concern.

In 2017, these behaviors became so severe that Mr. X. harmed himself, injured his brother and mother, was handcuffed by police, transported by police cruiser to the hospital, and placed on a psychiatric hold. Were behaviors of this level to repeat he would be at risk of institutionalization or incarceration. Dr. D., who only started treating Mr. X. after this incident and after a change in medication, opined that Mr. X., "[b]ecause of his behavioral problems … requires substantial supported living services to keep him out of legal involvement with the police and preserve safety not only for M., but those around him." Further it was Dr. D.'s opinion that he required "**at least 20 hours of Day Habilitation support a week**" and without this level of support he would be **"**at risk for either legal involvement with the police and jail or institutionalization."[39]

While Mr. X.'s behavior has been largely stable since 2017, this stability is not dispositive evidence that the risk has vanished. Rather, it is evidence that his current PCSP—including the 20 hours of day habilitation—is effective and necessary to manage that risk. The stability is the *result* of the services, not a justification for removing them.

Further, Mr. X. is at risk of decompensation and regression that could erase some of this progress if his day habilitation is significantly reduced. In addition to Dr. D.'s medical opinion, the record contains clear evidence that when Mr. X.'s routine is changed, or he is unable to swim for more than a few days, his behaviors regress. During a family trip to Wisconsin, Mr. X. was without his swimming routine for approximately 10 days. His behavior noticeably worsened to the point where he had to be physically escorted, arm-in-arm, through the airport on the return journey. His loud vocalizations and physical behavior were significant enough to result in contact with an airport police officer. While his father was able to explain the situation, this incident shows that a reduction in his day habilitation services leads directly to behaviors that can attract police involvement, creating a tangible risk of incarceration. This risk is particularly acute, as Mr. X. is nonverbal and unable to communicate effectively with police on his own. While minor reductions might be manageable, the Division's proposed reduction, at 40 percent, is a major reduction that would, more likely than not, result in significant regression and decompensation.

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[39] Ex. 2.

2. Mr. X. Still Has a Critical Need for Additional Day Habilitation

Under 7 AAC 130.260(c)(1)(B), a recipient must also have a "critical need" for additional services due to specific circumstances. Mr. X. meets at least two of these criteria.

First, he has a degenerative condition that necessitates community-based activities to maintain his physical health.[40] As Dr. D.'s letter explained, the antipsychotic medication that is essential for Mr. X.'s behavioral stability unfortunately puts him at high risk for weight gain and metabolic syndrome. Mr. X. cannot consistently engage in sufficient exercise, other than swimming, to prevent this risk. Without swimming Mr. X. gains weight very quickly and would either put his physical health at risk, or he would have to reduce the dosage of medication that has been effective. As a result, daily swimming is "**medically necessary** to control his weight, glucose, and cholesterol."[41] Since swimming is an activity only available in the community, he has a critical need for day habilitation to mitigate this degenerative physical condition.

Second, and more significantly, he exhibits behaviors that create a risk of physical harm that can only be mitigated by developing skills in the community.[42] While his aggression has improved since 2017, the record shows he still hits, slaps, and punches his family members and care providers. Testimony from Ms. Z., Mr. N., and Mrs. X. established that swimming provides a full-body workout utilizing all of his gross motor skills, which is highly effective at reducing stimming and maintaining a balanced emotional state. As swimming is the only physical activity he will consistently engage in to achieve this regulation, this community-based activity is the only proven method to mitigate the behaviors that pose a risk of harm to himself and others.

Finally, it is not possible to include the amount of swimming Mr. X. needs to control his physical and behavioral health with 12 hours of day habilitation. While Mrs. X. is able to get her son through his swimming routine in 90 minutes, his care staff regularly takes three hours to get Mr. X. through the entire process.[43] When combined with the other important goals of Mr. X.'s day habilitation, 12 hours of day habilitation is not sufficient.

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40 7 AAC 130.260(c)(1)(B)(i).
41 Ex. 2.
42 7 AAC 130.260(c)(1)(B)(ii).
43 Testimony of Mrs. X. *See also* Testimony of Mr. N.

3. The Additional Day Habilitation Services are Adequately Supported by Documentation

While the regulation has changed, the Division had previously found that the 20 hours of day habilitation were "justified as necessary to protect health and safety. This is due to critical behaviors that are of high risk to M. and others."[44] His current plan follows a similar justification. In explaining his needs Mr. X.'s PCSP notes:

> M.'s self-stimulatory behaviors or reactions to undesirable tasks **may escalate into loud outbursts and physical reenactments** of movie scenes. During these episodes, he often lacks situational awareness, potentially leading to unintentional contact with nearby individuals, including staff and family members. **In some cases, he may exhibit aggressive physical behaviors, including forceful punching, kicking, and strangling, particularly in confined spaces such as a vehicle**. He has also **engaged in self-harm behaviors, such as banging his head against glass or hard surfaces**.
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> **To enhance M.'s success, it is crucial to provide an active lifestyle rich in activities that allow him to expend energy, whether through productive tasks or physical exertion.** Incorporating frequent opportunities for short breaks into his routine is vital.
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> Activities should be structured into manageable time blocks of 1-3 hours, followed by extended breaks that include free time, snacks, and opportunities for self-expression (stimming) either at home or outdoors. **M. thrives when engaged and physically active**, underscoring the need for consistent stimulation and movement in his daily life.[45]

His PCSP goes on to note that swimming laps at the pool every weekday, "provides a crucial outlet for physical activity and energy expenditure."[46] The plan explains that, "[h]is emotional regulation is impaired, leading to difficulties managing frustration or overwhelming emotions" and when he is "unable to express his desires or needs, he may resort to physical outbursts that include lunging, hitting, punching, kicking, or strangling, displaying significant physical strength."[47] The plan highlights that, "[h]is need for constant movement is profound; Louie thrives on physical activity and becomes agitated when required to wait for extended periods."[48] His day habilitation goals include a goal of at least 60 minutes of physical activity each shift and go into detail on how this can be accomplished through swimming. This plan was further

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44 Ex. G, p. 69.
45 Ex. G, p. 57 (emphasis added).
46 Ex. G, p. 61.
47 Ex. G. p. 63.
48 Ex. G. p. 63.

supported by a letter from Mr. N., who has supervised Mr. X.'s care staff for six years. Mr. N.'s letter explained that Mr. X. "has a history of challenging, and at times aggressive behaviors" and that any reduction in day habilitation services "will simultaneously destabilize him, increasing the intensity of the level of support he requires, while also removing a large percentage of those crucial supports."[49] Mr. N. goes on further to opine that a cut to these services would "almost certainly result" in Mr. X. being placed in a facility outside of his community, a psychiatric hospital, "or worst case scenario and out of state placement."[50]

Additionally, Mr. X.'s file includes years of support plans, medical records, and incident reports – including the report of the 2017 incident that resulted in injury, police contact, and hospitalization. The Division seemingly believed that it could not approve hours above the soft cap, if there were no critical incident reports within the last year and also seemed to believe it could not rely on prior years' plans. While more recent information and more recent incidents are certainly *more* persuasive, the regulation makes clear that the records that can be relied on include "current and *prior year* support plans."[51] Additionally, while critical incident reports are certainly persuasive in determining a recipient's current needs, the regulation does not require that there be a reported critical incident within the prior year.

Finally, after submitting the proposed PCSP in this case, Mr. X.'s team submitted the letter from Dr. D. With his doctor's letter Mr. X.'s team demonstrated that, it was more likely than not, the submitted PCSP and supporting records, including prior years' plans, medical, social, educational, and other records, support both the need for and Mr. X.'s capacity to benefit from the full amount of requested additional day habilitation (4160 units) and satisfy the requirements of 7 AAC 130.260(c) for authorization of those services. However, it should be noted that a PCSP must be complete and comprehensible on its own, without requiring supplementation through testimony at a hearing. A core purpose of the PCSP and its supporting documentation is to provide the Division reviewer with sufficient information—prepared by the care coordinator through case planning and consultation with the recipient and care team—to

[49] Ex. G, p. 147.
[50] Ex. G. p. 147.
[51] 7 AAC 130.260(c)(1)(C)(ii).

make an accurate and informed determination.[52] A more detailed support plan may have precluded the need for a contested hearing and testimony from Mr. X.'s team.

However, for the reasons stated above, the Division has not met its overall burden of proof to show that Mr. X. does not satisfy the requirements of 7 AAC 130.260.

IV. Conclusion

Mr. X. is a disabled adult who has benefited from 20 hours of day habilitation services for many years. There is sufficient evidence that Mr. X. has a critical need for this level of day habilitation services. Further, the evidence in the record shows that he is at a risk of either institutionalization or incarceration if 20 hours of day habilitation services are not provided, and he is otherwise eligible to receive day habilitation hours in excess of the regulatory soft cap of 12 hours per week. The Division's reduction of his day habilitation hours for his 2025 – 2026 Medicaid Waiver PCSP is REVERSED.

Dated: November 18, 2025

By: *Signed*
Signature
Eric M. Salinger
Name
Administrative Law Judge
Title

[52] 7 AAC 130.217; Care Coordination Services and Long Term Services and Supports Targeted Case Management Conditions of Participation, dated July 1, 2022, adopted by reference in 7 AAC 160.900.

Adoption

The undersigned, by delegation from the Commissioner of Health, 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 18th day of November, 2025.

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

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