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

In the Matter of	)	
	)	
K. L.-H.	)	OAH No. 25-1969-MDS
	)	

FINAL DECISION [1]

I. Introduction

K. L.-H. is a disabled adult who receives services funded under the Intellectual and Developmental Disabilities Medicaid Home and Community-based Waiver program ("Waiver"). Through that program, Mr. L.-H. received twenty-eight hours a week of Day Habilitation (DH) services during the 2024 Waiver year. He applied for renewal of his Waiver benefits and submitted a Person-Centered Support Plan (PCSP) seeking to maintain his twenty-eight hours a week of DH services.

The Division of Senior and Disabilities Services ("Division") partially denied that renewal, providing him only eighteen hours-per-week of DH instead of the twenty-eight hours-per-week he received the prior plan year. To justify this denial, the Division pointed to a regulation they were applying to Mr. L.-H. for the first time and asserted that it only allowed a recipient to receive more than twelve weekly DH hours if his current condition put him at risk of institutionalization or incarceration without the additional hours. While the Division found sufficient support in the PCSP to award eighteen hours a week of DH, they stated further hours could not be justified without a critical incident report or evidence of a critical change. However, under 7 AAC 130.260 neither a critical incident report nor evidence of a critical change are required for Mr. L.-H. to qualify for his renewed benefits.

The Division here had the burden of demonstrating that it was probable that Mr. L.-H. did not qualify for the additional ten hours of DH and that the denial notice adequately justified that decision. As the Division failed to sufficiently explain their decision or account for the contents of the PCSP, it failed to meet that burden and its partial denial is REVERSED.

[1] A proposed decision was issued in this matter on November 14, 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 this decision to ensure clarity. The changes occur primarily on pages 10 and 17. The holding of the decision remains unchanged.

II. Background

Mr. L.-H. has participated in the IDD Waiver program for years. For example, in the 2023 Waiver year Mr. L.-H. was receiving 31 hours-per-week of DH services,[2] and during the 2024 Waiver year Mr. L.-H. requested and received twenty-eight hours-per-week of DH.[3] In addition to this requested reduction, the 2024 Waiver year was the first in which Mr. L.-H. did not receive additional support through education services as Mr. L.-H. aged out of public school.[4]

On April 4, 2025, Mr. L.-H. submitted an updated PCSP and applied for Waiver renewal.[5] In his renewal request, he requested that he continue to receive the same level of DH services as he had been receiving previously, twenty-eight hours a week. To justify this request, the PCSP contained various details about Mr. L.-H.'s history of institutionalization and aggressive and self-injurious behavior, as well as how the additional hours were crucial to ensuring his engagement with the community, reducing the frequency of his maladaptive behaviors, and avoiding institutionalization.[6]

After reviewing his renewal application, the Division requested more information on May 8, 2025.[7] On May 16, 2025, without receiving that information—and applying an amended regulation to Mr. L.-H. for the first time—the Division approved eighteen hours of DH per week, but it denied the remaining ten hours-per-week. The Division denied those hours "due to lack of justification and documentation sufficient to demonstrate a higher level of need."[8] The Division explained that the PCSP failed to provide enough specific and recent examples demonstrating that Mr. L.-H.'s current condition placed him at risk of institutionalization or incarceration without those ten DH hours. This is the only basis for the Division's denial in their notice and is thus the basis to be examined here.[9]

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[2] Ex. F at 11.
[3] *Id.*
[4] Ex. E at 11.
[5] Ex. C at 15.
[6] *See, e.g.,* Ex. E at 25.
[7] Ex. D at 3, 6. Sheagren Testimony.
[8] Ex. C at 18.
[9] *See generally, In re E. D.*, OAH No. 13-1369-MDS (Commissioner Health & Social Services, 2014) (available at https://aws.state.ak.us/OAH/Decision/Display?rec=2892)(holding that due process required written notices explain the reasons for a denial).

On June 13, 2025, a fair hearing on that denial was requested on Mr. L.-H.'s behalf.[10] Before hearing and during mediation, further documentation—such as letters of medical necessity—was submitted to the Division in an attempt to demonstrate Mr. L.-H.'s eligibility. Mediation was unsuccessful, and—after two continuances to allow for ongoing settlement negotiations and document review—a hearing was held on October 15, 2025.

Mr. H. and his fiancé B. F. appeared for hearing on behalf of Mr. L.-H. Also assisting was care coordinator U. T. and Waiver service provider D. Q. Victoria Cobo-George represented the Division with the assistance of Conner Sheagren, a Health Program Manager II with the Division who reviewed and partially denied Mr. L.-H.'s PCSP. At hearing, all the parties consented to an extension of the applicable deadlines in this case.

III. Facts

Mr. L.-H. is a 24-year-old man with pervasive level III autism spectrum disorder, Lenox-Gastaut syndrome, intermittent explosive disorder, sleeping disorders, eczema, constipation, and other medical conditions.[11] Given his disabilities, as of 2023 when it was last evaluated, his overall age equivalent was 2 years, 5 months old.[12] Mr. L.-H. experiences significant limitations related to his health conditions including having a tendency to harm himself, others, and property, and he has a history of institutionalization.[13]

In 2016, Mr. L.-H. was placed in emergency care at the Alaska Psychiatric hospital in Anchorage due to his aggressive and self-injurious behaviors.[14] He was then institutionalized and admitted to a residential facility in Kansas after it was determined that he was unable to be safe at home or in the community.[15] After receiving extensive therapy, he returned home in 2018 and his father and court appointed guardian, X. H.,[16] worked with TIDES LLC—a Waiver service provider—to develop strategies to address Mr. L.-H.'s challenges. With the full-time assistance of TIDES staff, Mr. L.-H. has been living in his own apartment for around seven years, but he still needs round-the-clock supervision due to his complex needs.[17] Mr. L.-H.'s apartment has

[10] Ex. C at 1.
[11] Ex. C at 13; Ex. E at 5 – 6.
[12] Ex. E at 28.
[13] *Id.*at 10, 28.
[14] *Id.* at 10.
[15] *Id.*
[16] Ex. C at 8.
[17] Ex. E at 10.

been reinforced with plywood to prevent him from damaging it and he is limited to using plastic dishware to avoid it being shattered during any outbursts.[18]

Mr. L.-H. has extremely limited communication skills for his age, largely using gestures or one or two words at a time.[19] Additionally, he has a limited awareness of danger or control over impulses. He needs close monitoring to safely access the community and is still learning how to avoid dangerous situations.[20] Mr. L.-H. benefits from receiving assistance from familiar staff that he knows and trusts.[21] He easily becomes agitated and dysregulated by overstimulation, and health issues such as constipation and insomnia.[22] When dysregulated, he struggles to tolerate being around others which hampers his ability to participate in the community.[23] Mr. L.-H. can escalate his behavior quickly, frequently resulting in very loud yelling and hissing sounds that can be alarming.[24] His complex needs, seizure disorder, and severe autism make him a poor candidate for group home living environments.[25]

As a result, he has been receiving DH for years.[26] In approving the prior year's DH hours under the prior regulation, the Division was required to find Mr. L.-H. previous PCSP—which is substantially similar to this year's PCSP—demonstrated the hours over the soft cap of twelve hours-per-week were necessary to protect the recipient's health and safety and prevent institutionalization.[27]

TIDES reports that, with the assistance of his twenty-eight weekly DH hours over the past year, Mr. L.-H. has made significant progress and had a substantial decrease in dangerous escalations both at home and in the community.[28] In February 2025 Mr. L.-H. even started his first work trial experience.[29] However, they caution that a resurgence of behaviors that had been moderated through the twenty-eight DH hours a week of hours could lead to staffing instability and housing ineligibility, as well as potentially cause re-institutionalization.[30] TIDES has stated

[18] *Id.*
[19] Ex. C at 13.
[20] *Id.*
[21] Ex. E at 27.
[22] *Id.*
[23] *Id.*
[24] *Id.* at 29.
[25] *Id.* at 10.
[26] *See, e.g.,* Ex. F at 11.
[27] 7 AAC 130.260(c) (As amended of October 5, 2017).
[28] Ex. G at 69.
[29] Ex. E at 11.
[30] Ex. E at 11 – 12.

they will not be able to continue working with Mr. L.-H. if his DH hours are reduced as they are already providing more services than they are paid for but cannot afford to do more unfunded work, and there are no other apparent options to assist Mr. L.-H.[31]

Dr. K. C., Mr. L.-H.'s physician, determined that Mr. L.-H. needs lots of exercise for weight management, sensory input, and to help regulate his bowels and sleep patterns.[32] Mr. L.-H. needs to walk for at least sixty minutes a day in his community as well as swim for one to two hours three to four times a week.[33] Without that exercise, Mr. L.-H. will suffer from severe insomnia that leads to an increase in dangerous behavior and seizure activities.[34] It also results in significant noise from his apartment at night in a manner that could jeopardize his housing.[35]

This exercise needs to occur outside the home to ensure Mr. L.-H. receives sufficient sensory stimulus and prevent an increase in self-injurious behaviors.[36] As Mr. L.-H. has been receiving significant amounts of DH for years, this community exercise has become part of his routine. A loss of DH hours would dysregulate Mr. L.-H., be detrimental to his health, and cause an increase in aggressive, destructive and self-injurious behavior.[37]

Mr. L.-H. reasonably takes longer to perform the physical activities than just the time for exercise ordered by his physician. Mr. L.-H. can take significant time transferring into and out of vehicles, as well as between stages of an activity or its associated preparation or cool down processes.[38] Similarly, Mr. L.-H. can lose focus during these crucial activities, delaying their accomplishment.[39]

A lack of sufficient daily physical activity or the disruption of his routine—such as that which may be caused by a loss of DH hours—can cause Mr. L.-H. to engage in more frequent and intense negative escalation. This kind of behavior has previously resulted in serious injuries to himself and staff, as well as significant property damage.[40] During the Covid-19 pandemic, when unable to swim and get sufficient stimulation out of the home, Mr. L.-H. became so agitated he concussed his staff, needed sedation, and had to be hospitalized and undergo surgery

[31] Ex. G at 71.
[32] Dr. K. C., MD, Letter of Medical Necessity (June 13, 2025).
[33] *Id.*, Ex. E at 11.
[34] *Id.*
[35] Ex. E at 29.
[36] Dr. K. C., MD, Letter of Medical Necessity (June 13, 2025).
[37] *Id.*
[38] Ex. E. at 19.
[39] *Id.* at 19 – 20.
[40] *Id.* at 27 – 28.

due to causing serious self-harm.[41] No events of equivalent seriousness have happened since then. While Mr. L.-H. had seven seizures during the 2024 Waiver year there were no emergency room visits, hospitalizations, significant constipation episodes, or eczema outbreaks.[42] However, over the past year Mr. L.-H. has experienced a handful of incidents of sudden and severe agitation, damaging his surroundings, and committing violence against himself and others.[43] This includes hitting his caretaker,[44] breaking mirrors and glass doors,[45] and running into walls and doors headfirst.[46] Given that all of these occurred outside of his apartment and all of these could easily have led to injury or legal action, such behaviors could lead to institutionalization or incarceration.

Mr. L.-H. has used his DH over the past year to build community relationships, reduce the occurrence of medical issues that contribute to escalatory behavior, and reduce the frequency and intensity of dangerous escalations.[47] Mr. L.-H.'s DH activities are focused on community integration and exercise and include the following:

- Swimming;[48]
- Walking trails;[49]
- Participating in group outdoor activities;[50]
- Volunteering; [51]
- Grocery shopping;[52]
- Attending a weekly peer date;[53]
- Practicing his personal safety, communication, and interpersonal skills;[54] and
- Being transported to and from those activities and completing related transitions.

IV. Discussion

A. Day Habilitation Hours and Applicable Regulations

DH hours 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

[41] Ex. C at 46 – 47.
[42] Ex. E at 5 – 6.
[43] Ex. G at 3.
[44] *Id.*
[45] *Id.* Ex. G at 5.
[46] Ex. G at 12.
[47] Ex. G at 69. Ex. E at 11.
[48] Ex. E at 45.
[49] *Id.* at 46.
[50] *Id.*
[51] *Id.* at 23 – 24, 52.
[52] *Id.* at 26.
[53] *Id.* at 51.
[54] *Id* at 47 – 51.

purpose of developing or retaining skills and functioning reasonably necessary for community integration."[55] The purpose of these services is to assist the recipient with acquiring, retaining, or improving their self-help, socialization, behavioral, and adaptive skills. The services may also reinforce skills taught in other settings, and promote the skills necessary for independence, autonomy, and community integration.[56]

The Division must approve each specific service as part of the Waiver recipient's Plan of Care. [57] DH hours are normally limited to a total of 624 hours per year. However, the Department may approve a limited amount of additional DH services if—

> (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;

[55] 7 AAC 130.260(b)(6)(A).
[56] 7 AAC 130.260(b).
[57] 7 AAC 130.217(b).

(iii) records maintained under 7 AAC 105.230(d);

(iv) direct service case notes;

(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.[58]

The term "risk of institutionalization" is defined by regulation as follows:

> "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.[59]

Additionally, in this regulation "critical need" is defined as a "… condition resulting from the recipient's circumstances that would result in institutionalization within the support plan year if additional day habitation services are not approved."[60]

Similarly, "limited amount" is defined as a DH service exceeding 624 hours a year "for which the department determines, on an hour-by-hour basis, that a recipient can reasonably be expected to engage in and benefit from active teaching or training, given that recipient's physical or behavioral condition."

The Division delayed implementation of this regulation due to the Covid-19 pandemic, and this is the first time this regulation has applied to Mr. L.-H..[61]

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

[58] 7 AAC 130.260(c).
[59] 7 AAC 130.319(20).
[60] 7 AAC 130.260(e)(1).
[61] Ex. F at 1.

reduction was correct.[62] In order to do this, the Division must prove that, for the ten denied weekly DH hours, the requirements of 7 AAC 130.260 were not met for the reasons they articulated in their denial notice, and, therefore, Mr. L.-H. no longer qualifies for those hours.

C. Basis for the Denial

In issuing its denial, the Division stated that a new[63] regulatory requirement was in place, imposing a soft cap of twelve hours of DH per week that could only be exceeded if "the recipient's current physical or behavioral condition places the recipient at risk of institutionalization or incarceration if additional DH services are not provided."[64] While the Division found that Mr. L.-H. was sufficiently at risk to exceed the soft cap, they found that the documentation he submitted failed to sufficiently demonstrate the denied ten additional hours-per-week was necessary to avoid institutionalization or incarceration.[65] In support, the denial notice makes broad generalized statements to claim that the PCSP was insufficient. It states "no specific examples were given in the Support Plan or in any of the additional documentation that show the frequency, content, or severity of Jivan's behavioral escalations,"[66] and "[t]he Support Plan gave no current and specific examples of how Jivan's behaviors are putting him at risk of institutionalization or incarceration."[67] The denial letter does not make any attempt to explain why, if, as it claims, the PCSP fails to contain any specific examples, the approved six hours over the soft cap was permissible. It also does not address at all how the Division determined that six extra hours were appropriate, but any more would be unjustifiable.

The Division's notice further stated that "[w]ithout a [Critical Incident Report] or evidence of a critical change in the individual's behavior that requires immediate intervention, we cannot justify the need for Day Hab hours beyond the eighteen hours approved."[68] But nothing in the regulation requires a critical incident report to exceed the soft-cap or plainly supports either of these supposed requirements. Moreover, the notice entirely fails to explain how a critical change can be required to remain eligible for benefits Mr. L.-H. was already receiving.

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[62] 7 AAC 49.135.
[63] The regulation appears to have been in effect for years but was, for various reasons, delayed in its implementation.
[64] Ex. D at 2.
[65] Ex. C at 18.
[66] *Id*.
[67] *Id*. at 17.
[68] Ex. D at 4.

The Division acknowledged in making its decision general event reports from the previous plan year,[69] but dismissed their relevance without explanation as insignificant because they were not critical incident reports. The notice failed to analyze the reports' contents or explain why they failed to support Mr. L.-H.'s request.[70] These events may not have resulted in harm to Mr. L.-H. or others, necessitated a peace officer response, or otherwise met the definition of a "critical incident" in 7 AAC 130.224. However, they involved breaking glass and attacking individuals, and posed a substantial risk of harm to both Mr. L.-H. and others.[71] This is particularly true as Mr. L.-H. had to undergo surgery for injuries he sustained breaking glass in a similar manner in 2021.[72] Accordingly, the failure of these events to qualify as critical incidents would appear to be more based on Mr. L.-H.'s and his caretaker's luck at not being injured, and TIDES close relationship with the owners of the damaged property than any lack of seriousness. An incident not rising to the level that requires a provider to report it as a "critical incident" under 7 AAC 130.224 does not automatically render the incident irrelevant to a DH analysis, particularly when the PCSP renewal request included a description of the incident for consideration by the Department.

Ultimately, the partial denial letter may have been based on an inappropriate or outdated template for a renewal situation as it contains a number of errors. For example, the letter criticizes Mr. L.-H. for failing to explore other resources before requesting an increase in DH,[73] when no increase was requested and the PCSP directly discusses the other resources that Mr. L.-H.'s team has explored.[74] More importantly, the notice baldly states Mr. L.-H. failed to demonstrate a higher level of need, instead of demonstrating in detail why the PCSP documentation justified eighteen hours a week of DH, but failed to provide sufficient support for weekly DH hours nineteen through twenty-eight.

In his testimony, the author of the denial letter, Mr. Sheagren, stated that his partial denial of Mr. L.-H.'s application was based on a lack of critical incident reports during the 2024 Waiver year and the application's failure to demonstrate the frequency, context, or severity of Mr. L.-H.'s escalations.

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[69] *Id.* at 3.
[70] *Id.*
[71] *See, e.g.,* Ex. G at 3, 5, 12.
[72] Ex. C at 46.
[73] Ex. C at 18.
[74] Ex. E at 12.

Even so, he approved exceeding the regulatory soft cap by six hours. Yet, despite the regulatory requirements, he could not confirm that in making his decision the Division had determined awarding only seventeen DH hours a week would put Mr. L.-H. at risk of institutionalization. Moreover, he testified that there was no formula or breakdown for precisely how the hours were allocated and he could not state how he determined that nineteen DH hours-per-week was too many. When asked to explain why eighteen hours was appropriate, but anything further was impermissible, he testified that his experienced supervisor—who did not testify—helped him determined that eighteen would be appropriate. In explaining how they found that number was appropriate, he cited the letter from Mr. L.-H.'s doctor stating that Mr. L.-H. needed fifteen hours of specific physical activity a week[75] and stated the Division felt that three DH hours-per-week on top of those exercise hours were sufficient for Mr. L.-H. to work on any other community-based skills that could not also be addressed while completing those physical activities. However, the Division did not address Mr. L.-H.'s other goals in any detail whatsoever, merely stating they could be completed in three hours a week. While it is reasonable to think that during walks and transportation Mr. L.-H. could also be practicing his safety, interpersonal, and communication skills, his goals to complete volunteer activities and attend peer dates overlap far less cleanly with swimming and hiking, and those goals were not mentioned or addressed in any way by the Division's attempts to justify their partial denial. Mr. L.-H.'s final goal, grocery shopping, was only addressed briefly by the Division at hearing to suggest that grocery shopping should be billed to supported living hours instead of DH, even though it aligns with Mr. L.-H.'s goals for DH.

Finally, the Division also failed to address how their analysis accounted for round trip transportation to the location where DH services are provided—something that is explicitly included in DH services by the applicable regulation.[76] When asked how the Division accounted for Mr. L.-H.'s transition periods and transportation to and from activities in his assessment of the application, Mr. Sheagren merely testified that the PCSP failed to discuss the time necessary

[75] While that doctor's letter was not submitted until a month after the Division made their decision—and thus could not form the basis of Mr. Sheagren's decision—it seems probable that Mr. Sheagren was simply remembering similar recommendations in the PCSP.
[76] 7 AAC 130.260(b)(2).

for transitions or transportation. However, he failed to articulate in any way why the PCSP's repeated references to transitions and travel[77] were insufficient.

Altogether, this means the Division's denial failed to articulate how, based on the specifics of the PCSP that was submitted, it determined eighteen hours of DH a week was appropriate, but twenty-eight hours was excessive.

D. Analysis

While there is no question the PCSP in this case could be improved to more clearly provide hour-by-hour justifications for Mr. L.-H.'s DH request, the burden here was on the Division to explain in their denial why the PCSP was deficient and provide Mr. L.-H. with notice and the information needed to, if possible, address those deficiencies in the future. "To satisfy due process, the notice must show how and why the [Division] determined that a reduced level of benefits was warranted."[78] Because the Division's denial was based on broad conclusory statements, justified severely cutting longstanding benefits intended to reduce the risk of institutionalization because they did their job, and failed to properly determine how many DH hours were necessary to enable even the exercise it found critical, the Division failed to meet that burden here.

While the Division has only recently begun to implement the updated 7 AAC 130.260(c), this is not the first case involving the Division attempting to reduce prior recipients' DH hours based on that regulation. In deciding 24-0738-MDS, the Commissioner determined the Division's notice of partial denial there was flawed because it did not fully articulate specific deficiencies in the submitted PCSP. [79] He further faulted it for failing "to articulate that, in particular, the PCSP must communicate how the *additional* requested services, on an hour-by-hour basis, will contribute to accomplishing the outcomes and goals identified in the recipient's support plan."[80] Instead of doing this, he noted negatively that "the Division's denial letter focused on lack of documentation of critical incidents." As he found:

> CIRs are not a required element for approval of additional day habilitation services. They are merely one type of documentation that may support such a request. Their absence, particularly when not clearly required under the facts of the case, is not a sufficient basis

[77] *See infra*, at 13 – 15.
[78] *Baker v. State, Dep't of Health & Soc. Servs*., 191 P.3d 1005, 1010 (Alaska 2008).
[79] *Corrected Non-Adoption Decision,* OAH case No. 24-0738-MDS (Comm. of Health, June 25, 2025).
[80] *Id.*

> to deny services that may otherwise be justified based on the recipient's needs and capacity to benefit from them.[81]

The Division's denial here is quite similar to the one at issue in that case. It plainly refused to award more than eighteen hours of DH per week without a critical incident report and provided no analysis of how the Division determined eighteen hours-per-week of DH, but no more, was appropriate.

While the denial notice here focused slightly more on a lack of specific current examples of problematic behavior, it did nothing to explain why the examples in the PCSP were insufficient or demonstrate how they justified awarding six DH hours-per-week over the soft cap, but not sixteen. 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 for evidence of critical incidents. 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 documentation from a prior plan year."[82] While there may be valid reasons to weigh historic incidents differently, the Division did not articulate any of them here. Arguing that a grant of DH that has helped to successfully reduce problem behavior is excessive because there are insufficient ongoing problem behaviors is not persuasive. It would trap Waiver recipients in a cycle of constantly bouncing between being supported by DH assistance only to lose it as punishment for that DH doing what it was designed to do. This does not mean DH can never be reduced—as it is quite reasonable to hope that Waiver recipients make progress towards their goals and might eventually not need DH hours at all. However, the Division's partial denial is not a minor change, it is a reduction of Mr. L.-H.'s DH by over a third. This is a very significant and sharp reduction, and the Division has presented nothing to demonstrate that such a reduction will not cause a substantial increase in Mr. L.-H.'s detrimental behaviors.

Most importantly, by justifying its approval of eighteen DH hours-per-week using merely the time Mr. L.-H. needed to be actively exercising plus three hours, the Division conceded that the time necessary to complete that exercise and do three other hours of DH met the regulatory standard to exceed the soft cap. The problem with basing the partial denial on that calculation,

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[81] *Id.*
[82] 7 AAC 130.260(c)(1)(C).

however, is that, as Mr. L.-H.'s team argued, it takes much longer than fifteen hours for Mr. L.-H. to complete fifteen hours of exercise. The Division's supposed justification for why eighteen hours was appropriate ignores that swimming and walking community trails require activities such as transportation to the pool and trails, transitions in and out of vehicles, changing, and showering. While Mr. Sheagren acknowledged these activities could be covered by DH, he testified that he saw no support for those transitional and transportation requirements in the PCSP. That testimony conflicts with the PCSP.

The PCSP directly states that swimming is a long process for Mr. L.-H. "with lots of transitions," and that he struggles to complete the various steps only completing them without aggressive and self-injurious behavior 51 percent of the time.[83] Additionally, while the PCSP could explicitly state that it is not a private pool at Mr. L.-H.'s apartment—that seems like a reasonable assumption and there are repeated references to the need to travel to the pool in the PCSP.[84] This includes explicit care calendar entries that include traveling to the pool, preparing to swim, and completing the routine after swimming as DH hours.[85]

The same is true for Mr. L.-H.'s walks in the community. Dr. C. says that Mr. L.-H. needs to hike for at least sixty minutes a day, but that does not mean that he only needs to dedicate sixty minutes of DH a day to walking. It means he actually needs to physically be walking in the community for at least sixty minutes a day. The PCSP states Mr. L.-H. goes on group hikes,[86] takes breaks while walking,[87] visits trails all around the community,[88] and sometimes needs to be prompted to resume or engage in his activities.[89] "Travel to trail," and "travel to pool" are even explicitly listed uses of prior DH hours.[90] Similarly, the PCSP describes delays with walking as Mr. L.-H. can lose focus and sit down or turn back and sets goals for Mr. L.-H. to respond to prompts to continue within five or fifteen minutes.[91] All of that indicates that even once the hour walk has begun, it is improbable that it continues the entire hour without interruption. All of those factors represent additional time necessary for Mr. L.-H. to complete

[83] Ex. E at 19.
[84] Ex. E at 48.
[85] Ex. G at 75.
[86] Ex. E at 20.
[87] Ex. G at 81.
[88] *See, e.g., Id.* at 82 – 83.
[89] Ex. E at 19 – 20.
[90] Ex. G at 75.
[91] Ex. E. at 19 – 20.

the medically necessary exercise that the Division has already found is worthy of exceeding the soft cap to complete.

While previous PCSPs explicitly state that Mr. L.-H. will occasionally refuse to get out of the vehicle to go to the pool, they acknowledge that behavior is decreasing.[92] The prior PCSP included goals for transitioning between activities and out of vehicles within 5 minutes.[93] Those goals were completed over 95% of the time, and Mr. L.-H.'s goal this Waiver year is to transition without a five-minute delay.[94] That is significant progress from Mr. L.-H.'s prior goal of avoiding an over fifteen-minute delay, but it is still evidence that transitions in and out of the vehicle take some time. Even if that five minutes is not a delay in getting started and represents the entire transition process, that's still five minutes necessary at every single transition between activities and out of vehicles.

For all of these reasons, while the PCSP certainly could have been more explicit in presenting how these factors compound and amount to a significant use of DH hours, the PCSP does demonstrate Mr. L.-H. needs more than the fifteen hours allotted by the Division to complete his medically required fifteen hours of exercise.

Four two-hour swim sessions a week and seven hour-long community walks a week, mean twenty-two car rides of unknown length. If every one of those drives only takes ten minutes that represents 220 minutes a week. It also includes forty-four transitions into and out of those vehicles—transitions where Mr. L.-H. meets his prior year's goal if he can complete them within five minutes. That represents another 220 minutes a week just for transitions to get to those activities for which the Division determined Mr. L.-H. should be awarded DH hours. Further time is needed to find parking, change clothes, wash off, hydrate, and rest, as well as account for other small tasks and distractions during those activities. The record also demonstrates Mr. L.-H. sometimes needs encouragement to start or continue these medically necessary activities. If all those additional tasks and distractions only add fifteen minutes to each outing it would be impressive given Mr. L.-H.'s difficulties, but that represents another 165 minutes a week. In total, that is over ten additional hours a week that could be necessary to enable Mr. L.-H. to complete the fifteen hours of exercise a week that the Division has already

[92] Ex. F at 22.
[93] *Id*. at 21 – 22.
[94] *Id.*

acknowledged are medically necessary and meet the criteria to exceed the soft-cap. While admittedly roughly estimated, together that represents over twenty-five hours of DH a week just to enable Mr. L.-H. to complete the exercise for which the Division has already found the soft-cap can be exceeded.

These are obviously approximations, but they demonstrate Mr. L.-H. clearly identified in his PCSP a need for more than merely just walking and swimming time to complete the physical activity that is crucial for reducing his harmful and maladaptive behaviors. That the Division found no support for this time worth addressing at all in their decision is problematic. If the Division took issue with these characterizations, believed they were unjustified or could not be used as DH hours, it could have made a case against their inclusion in such a calculation. But it presented no such claim in its denial notice or at hearing. All that the Division provided was broad, unsupported statements that there was insufficient documentation to support the claim. That is insufficient to meet the Division's burden in the face of the PCSP's details discussed above.

Additionally, the Division already testified without explanation that they thought three hours for all of Mr. L.-H.'s other goals was sufficient. Combined with the previously discussed twenty-five hours, that would be twenty-eight hours of DH a week, the amount Mr. L.-H. was previously approved for and is requesting. And that is assuming three hours is sufficient for all of Mr. L.-H.'s other goals. Mr. L.-H. is capable of participating in skill-building activities during transportation, walking, and potentially some transitions, so it is understandable to not provide a large amount of time solely for those activities. However, given that he also tries to participate in at least two volunteer activities a week, go grocery shopping, and complete at least one peer date, it is easily imagined that more than three hours might be necessary, but the Division did nothing to justify or show how they arrived at three as a reasonable amount.

The Division's failure to identify how they determined the appropriate amount of DH here or grapple with the evidence in the PCSP renders the foundations of its decision and notice defective. By not demonstrating how it made its decision the Division is preventing Mr. L.-H. from showing how the decision-making may be flawed. Moreover, by justifying its decision to award eighteen hours-per-week on nothing more than the time Mr. L.-H. needed each week to complete his medically required fifteen hours-per-week of exercise—plus three hours a week for everything else—the Division implicitly agreed that the soft-cap could be exceeded for the time

actually necessary each week for Mr. L.-H. to complete his medically required fifteen hours of exercise plus three. That is the Division's only justification for why it exceeded the soft cap here. Combined with the evidence in the PCSP showing that fifteen hours is not enough time to complete fifteen hours of exercise, and the Division's failure to grapple with that evidence at all, the Division presented no real argument showing why Mr. L.-H. is ineligible for more than eighteen DH hours a week. The precise number of appropriate DH hours is certainly up for debate given the above calculation relies on numerous assumptions. But the Division failed to engage with any of the available evidence in the PCSP to determine in detail how much DH is necessary to enable the exercise it concedes is necessary. Accordingly, the Division's partial denial must be reversed because the Division failed to meet their burden to show how Mr. L.-H. no longer qualified for those ten DH hours a week.

IV. Conclusion

Because its decision was based on misstatements of law as well as broad conclusory assertions and it failed to closely analyze how many DH hours were necessary to enable even the exercise it found critical, the Division failed to demonstrate that Mr. L.-H. no longer qualified for twenty-eight DH hours a week. To demonstrate that Mr. L.-H. should have lost some of his DH hours, the Division needed to affirmatively demonstrate he no longer qualified by closely examining the PCSP, showing how it failed to meet the applicable standard, and detailing in its notice how the Division determined its eventual award was appropriate. As the Division failed to do so, and admitted Mr. L.-H.'s need for exercise was worth exceeding the soft cap but failed to properly account for the hours necessary to complete that exercise, the Division's decision to deny the extra ten hours-per-week of DH is REVERSED.

Dated: Nunc pro tunc November 14, 2025

By: *Signed*
Signature
Garrison A. Todd
Name
Administrative Law Judge
Title

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 5th day of December 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.]