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

In the Matter of	)	
	)	
Q.J	)	OAH No. 26-0203-MDS
	)	

DECISION

I. Introduction

Q.J is a child with autism and epilepsy who applied for services funded under the Children with Complex Medical Conditions Medicaid Home and Community-Based Waiver Program. The Division of Senior and Disabilities Services denied his application after finding Q did not require a nursing facility level of care (NFLOC). Q's father, C.J (herein "Mr. J") argues that Q requires NFLOC because his medications need frequent adjustment and oversight, he is at risk for life-threatening seizures, and he requires skilled 24/7 monitoring. Q's medications are only adjusted a few times a year, his seizures are infrequent, and his rescue medication can be administered by laypeople. Similarly, while he receives constant supervision, it is by laypeople, and the record does not demonstrate he has ever had or required constant professional supervision. The evidence thus demonstrates that Q does not require NFLOC. Therefore, the Division's decision is AFFIRMED.

II. Background

a. Legal Background

Q applied for Medicaid Home and Community-Based Waiver for Children with Complex Medical Conditions (CCMC). To qualify for CCMC waiver, Q must meet seven criteria.[1] The only criterion at issue here is that Q must require NFLOC—the level of care provided by either an intermediate or skilled nursing facility. [2]

The Division determines whether a CCMC waiver applicant meets that requirement using a Nursing Facility Level of Care Assessment Form for Children (the "Form"), adopted by regulation.[3] Although the Division is required to use the Form's results to determine whether NFLOC is required, the Form does not contain a formula that determines if an applicant requires NFLOC. Nor did the Division identify specific criteria on the Form that, if met, demonstrate an

[1] 7 AAC 130.205(d)(1).
[2] 7 AAC 130.205(d)(1)(G); 7 AAC 130.215(1).
[3] 7 AAC 130.215(1). *See also* 7 AAC 160.900 (adopting that form into regulation).

applicant requires NFLOC. Division assessors instead use the Form as a tool to conduct a holistic medical review and determine an applicant's level of care.[4] Using the Form, the assessor examines the applicant's medical history, medications, and need for assistive devices. They also examine an applicant's ability to complete activities of daily living, evaluate cognitive and behavioral issues, and consider factors that might indicate a child could be institutionalized, such as technology dependence, need for skilled assistance, or need for round-the-clock monitoring and support.[5]

b. Factual Background

Q is a nine-year-old with epilepsy, autism, ADHD, and mixed receptive expressive language disorder.[6] He was hospitalized in 2019 when he suffered his first seizure at age two, and he has had confirmed seizures between 2021 and 2025.[7] He has not been hospitalized for any other seizures, though emergency services were called for one in 2024.[8] Q is at risk of status epilepticus, a state where seizures do not stop on their own and can lead to permanent injury or death. He has needed rescue medication, in the form of a nasal spray administrable by a layperson, to stop some seizures.[9] Mr. J believes Q's status epilepticus after his first seizure caused his developmental issues.[10] In addition to always having rescue medication on hand, Q takes multiple anti-seizure medications every day.[11] His dosage is periodically adjusted based on his weight to ensure consistent dose per kilogram.[12]

Q is continuously supervised by his father, as his full-time caregiver, or by his bus driver or school staff. Q's mother is an obstetrician-gynecologist.[13] Q had only two doctors' appointments in the year prior to his assessment: one annual well check, and one neurologist appointment.[14]

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[4] S. Catania testimony.
[5] Ex. E.
[6] Ex. E at 2; Ex. G at 12, 14. Ex. 2. Q's specific epilepsy diagnosis may be evolving. Some physicians identified it as intractable focal epilepsy and others as benign occipital epilepsy of childhood. *See, e.g.,* Ex. E at 2 (recapping medical records that describe it differently); c*ompare* Ex. 2, Dr. Fahl's letter, *with* Ex. G at 14. The correct specific diagnosis is not determinative. Instead, the specific symptoms Q experiences are determinative here.
[7] C.J testimony; Ex. G at 64-65, 75.
[8] Ex. G at 65.
[9] Ex G at 30, 33; C.J testimony; S. Catania testimony.
[10] C.J testimony.
[11] *Id.* at 6, 30.
[12] Ex. G at 33.
[13] *Id*. Ex. 4, Q's Individualized Education Program, at 6.
[14] Ex. E at 2.

Q's last confirmed seizure was in the summer of 2025.[15] Around that time, his medications were adjusted.[16] Mr. J suspects Q experiences ongoing nighttime seizures based on what he believes are post-seizure symptoms.[17] He cannot, however, confirm any seizures have occurred.[18]

Division assessor Stacy Catania evaluated Q for CCMC eligibility. She is a nurse and experienced at assessing CCMC applicants. She also estimated she had eight years of experience with direct care for children with seizure disorders.[19] She found Q did not require NFLOC and was thus ineligible for CCMC.[20] A second Division assessor, Paula Ray, RN, reviewed the assessment and concurred.[21] The Division denied Q's CCMC application on that basis.[22]

III. Discussion

a. Q Has the Burden of Proof and No Presumption Exists that Q Requires NFLOC.

An initial CCMC applicant has the burden of proof to demonstrate eligibility by a preponderance of the evidence.[23] Here, that means Mr. J must demonstrate it is more likely than not that Q requires NFLOC.

Mr. J claims the Division must overcome a presumption in Q's favor because, as he argues, Q's treating physicians unanimously agree NFLOC is required. However, whether Q requires this level of care is a legal conclusion, not a medical one. While their medical opinions about Q's medical condition and needs provide relevant evidence, a doctor's conclusion about how the Division should interpret and apply the law is not. The burden remains with Mr. J.

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[15] The record is unclear on this point. Mr. J testified the last confirmed seizure was in August 2025, but that was not disclosed in the seizure history he provided in November 2025. Ex. G at 7, 64. Medical records from September 2025, also state the last confirmed seizure was on June 24, 2025. Ex. G at 30. Those same records state there was merely a suspected seizure in August 2025. *Id.* The assessment found the last seizure was in July 2025. Ex. E at 9. The precise date is irrelevant as Mr. J did not dispute that it had been a long time since the last confirmed seizure.
[16] C.J testimony. S*ee e.g.,* Ex G at 64.
[17] Mr. J testified that Dr. J believes these to be post seizure symptoms as well. However, while Dr. J has worked to learn more about Q's condition and sometimes treats physical injuries he receives, Mr. J admitted he could not state she acts as a treating physician towards Q's epilepsy or that she is capable of making medical judgments about his neurological condition.
[18] C.J testimony.
[19] S. Catania testimony.
[20] Ex. D at 1; Ex. E.
[21] S. Catania testimony.
[22] Ex. D at 2. Though the Division argued at hearing the denial was required due to Q's failure to meet other CCMC criteria as well, this is the only basis for denial given in their notice. As this hearing is on an initial denial of benefits and can be decided on the Division's cited basis here, that is less problematic than it could have been. However, the Division should ensure that its future notices in CCMC denials are more comprehensive if it wants to argue, as it did here, that multiple requirements of 7 AAC 130.205(d)(1) support a denial.
[23] 7 AAC 49.135.

b. Q Does Not Require a Nursing Facility Level of Care.

1. Q Does Not Require a Skilled Nursing Facility Level of Care.

There are two categories of nursing facility care: intermediate and skilled. A skilled level of care is needed when a person requires treatment for an unstable condition by technical or professional personnel, at the direction of a physician.[24] Mr. J asserts that Q is unstable and requires skilled nursing services since his seizures can cause permanent regressions.[25] All parties agree that Q's needs are complex. But Ms. Catania credibly testified that medical instability involves a need for frequent medical interventions and that is not present here.[26] Q attends school, goes on vacation, and enjoys hiking and skiing.[27] Q's physicians describe his seizures as medically maintained.[28] His last confirmed seizure was in the summer of 2025 and he has not been hospitalized since 2019.[29] Q's needs have been met without frequent medical interventions for years. No evidence suggests he is deteriorating. These are strong indications he is not unstable.

Nor does the evidence support finding that Q's doctors have directed treatment by technical or professional personnel. Mr. J provides the majority of Q's care. While he no doubt provides quality, loving care, he is no medical professional. The only urgent medical intervention Q has required for seizures in recent years is a simple nasal spray that Mr. J or any other layperson may administer.

Accordingly, Mr. J has not demonstrated Q requires skilled nursing care under 7 AAC 140.515.

2. Q Does Not Require an Intermediate Nursing Facility Level of Care.

Intermediate nursing facility services are necessary treatments for a stable condition, at the direction of a physician, and provided by a nurse or medical professional or person supervised by a licensed nurse or therapist.[30] There is no evidence in the record of a physician

[24] 7 AAC 140.515(a).
[25] At hearing, Mr. J cited various laws and regulations that he believed supported his case. While some were valid, he also included citations such as 7 AAC 130.201(b)(5), and 7 AAC 130.211(a)(1)(C)—which do not appear to exist—and other citations that do not seem to address the issues Mr. J believes they do. The undersigned believes these are likely the results of AI hallucinations. If that is the case, the undersigned understands the allure of these tools but cautions that they can be severely misleading and are unreliable.
[26] S. Catania testimony.
[27] Ex. G at 18, 40, 66.
[28] Ex. 1.
[29] C.J testimony.
[30] 7 AAC 140.510.

prescribing such services for seizures or any of Q's other conditions. The letters Q's physicians and therapists submitted generally described Q's condition and advocated on his behalf. They identified various reasons why Q is medically complex and requires extraordinary supervision.[31] However, no physician ordered or prescribed services that need professional administration. As intermediate nursing facility services must be ordered by a physician, that omission is significant.

Nonetheless, Mr. J argues that Q requires intermediate nursing facility services for three primary reasons. Each is addressed below, but none of these arguments are persuasive here.

First, Mr. J alleges Q requires constant medication management and medical oversight for his active epilepsy. The record does not support this assertion. Mr. J asserts that Q's medications require constant adjustment, but the record shows that Q's medications are adjusted infrequently based on his growth.[32] It does not take a professional to keep track of Q's weight and talk to a physician about increasing his dosage. This is particularly true because the record shows Q's physicians warn in advance that the dose may need to be increased when Q reaches a specific weight.[33] Mr. J also argues that Q requires frequent professional medical oversight. Q, however, had only one doctor's appointment in the year prior to his assessment that was not an annual well check.[34] Ms. Catania credibly testified that the only children she is aware of who have qualified for CCMC waiver based on seizures require more frequent adjustments to their medications and have more frequent appointments with their doctors.[35] A need for occasional doctor's appointments and predictable increases in medication does not demonstrate a need for intermediate nursing services.

Second, Mr. J alleges the constant threat of seizures, combined with Q's other diagnoses, are sufficient to require intermediate nursing services. He analogizes Q's need for services to a city's need for a bomb squad—always needed even if there is not necessarily a daily emergency. As he argues, Q's need for constant supervision and assistance with activities of daily life demonstrate professional care is required. While these arguments may demonstrate Q needs 24/7 supervision, they fail to demonstrate a need for professional services.

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[31] *See generally* Ex. 1 – 2, 5 – 6.
[32] In October 2025, Q's neurologist indicated Q's dose was increased in January 2024 and in June 2025. Mr. J stated Q's medications were last adjusted in December 2025. C.J testimony. Ex. G at 30, 33.
[33] Ex. G at 33.
[34] Ex. E at 2.
[35] S. Catania testimony.

Ms. Catania credibly testified that the only children she is aware of who have qualified for CCMC based on seizures need assistance with uncontrolled seizures multiple times a week.[36] That testimony is bolstered by the fact that it is consistent with how adopted requirements governing a similar waiver program for adults explicitly require seizures to occur multiple times a week to contribute to finding an adult requires NFLOC.[37] In contrast, Q's condition is maintained on anti-seizure medications and confirmed seizures are rare—with the last occurring approximately a year ago.[38] The record does not demonstrate Mr. J even suspects Q suffers seizures on close to a weekly basis, let alone multiple times a week.

Nor do the complications of Q's comorbidities enhance the risk of his seizures in a manner requiring intermediate services. Mr. J argued that Q's communication difficulties compound the risk from his seizures because Q is unable to report subtle neurological changes or escalating distress that could trigger or be evidence of a seizure.[39] While the assessment found Q shy, Mr. J's report and his exhibits demonstrate Q is far from nonverbal, and his therapist specifically noted he was able to verbally request help.[40] Additionally, Mr. J indicated they currently defray any risk that might be posed by Q's inability to communicate subtle issues by keeping him under layperson observation 24/7. Mr. J did not demonstrate that layperson observation was somehow inadequate in a manner that professional services were necessary. Accordingly, Q's language difficulties also do not exacerbate his seizure risk in a way that requires NFLOC.

Similarly, no evidence suggests Q's diagnoses leave him unable to complete the activities of daily life without intermediate services. Mr. J claims Q's clumsiness and potential to have a seizure render him a high fall risk in need of NFLOC.[41] While a sudden seizure could cause Q to fall, nothing suggests Q has a history of falling during seizures or that movement is a trigger for his seizures. Q is in the running club at school and Mr. J himself discussed concerns with Q running off into traffic.[42] Even if he may be uncoordinated, the record indicates that Q can and

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[36] *Id.*
[37] *See generally, In re. X.M.*, OAH Case No. 15-0090-MDS, at 3, (Health & Soc. Serv., 2015) https://aws.state.ak.us/OAH/Decision/Display?rec=2941 (discussing how weekly direct assistance to manage seizures is required to qualify for a similar waiver by having a seizure disorder).
[38] S. Catania testimony; Ex. 1; C.J testimony.
[39] C.J testimony.
[40] Ex. 4 at 4; Ex. E at 5; Ex. G at 60.
[41] C.J testimony.
[42] Ex. G at 49, 65.

does physically walk and run independently. Q's overconfidence and lack of danger awareness is of understandable concern to his parents. It is not an indication, however, that he needs the support of a professional to move around his home.

Nor does Q's need for extra assistance with toileting, bathing, dressing, grooming, eating, and skin care demonstrate that assistance needs to be from a professional. Needing additional assistance and supervision is not sufficient to demonstrate that professional assistance and supervision is required. No evidence suggests professional assistance under the direction of a physician is necessary to help Q dress properly, eat slower, brush his teeth and hair, or adequately clean his hands and body. There is no question Q struggles in these areas for his age, and his family provide crucial assistance, but nothing suggests that assistance is the kind a doctor needs to prescribe. Therefore they are not sufficient to demonstrate Q requires intermediate nursing services.

Mr. J's final argument is that Q's current supervisors provide the equivalent of the type of professional services that would be provided in an intermediate nursing facility. He claims that this high quality care is the only reason why Q's health has been so stable, but that the family is no longer able to provide it without respite. While Mr. J's efforts on behalf of his son are admirable, the record does not support an argument that Q is currently receiving intermediate care. Mr. J did not provide any details of trainings provided to Q's teachers and bus drivers, or trainings that he has completed himself. Nothing in the record demonstrates why the tribunal should treat the care provided by Q's bus driver, for example, as equivalent to that provided by medical professionals. Dr. K. is a licensed professional—though admittedly in a significantly different field. However, even if her background might be sufficient, she is working to support her family and has not been Q's full-time caregiver. While Mr. J alleges Dr. K. can take care of seizure symptoms that might otherwise result in hospital visits such as U's paralysis, there are no details about those incidents or their frequency in the record.[43]

Mr. J argues that Q is being punished for having a dedicated support team, but that is not the case. Even if he was a skilled nurse parent, providing round-the-clock care for his child would not necessarily mean the child does need intermediate nursing facility care. The question is what services the child needs. Mr. J has not provided evidence that the services he or the school personnel provide are services that require medical supervision, such as the services that

[43] C.J testimony.

would qualify as intermediate nursing facility care. The fact that layperson care has successfully maintained Q's health simply undercuts Mr. J's contention that professional care is required. This is not to undervalue Mr. J's work in maintaining Q's health in any way. It is simply unavoidable that there is a distinction between needing layperson supervision to defray the risk from seizures and requiring services from a professional nurse.

For all of these reasons, Mr. J was unable to meet his burden here to demonstrate Q requires intermediate nursing facility services.

IV. Conclusion

Q does not require NFLOC and thus cannot be eligible for CCMC based waiver. Two different Division nurse assessors reached the same conclusion based on the assessment and their expertise. Mr. J was unable to demonstrate that Q requires NFLOC. He does not require frequent medical oversight, does not have frequent seizures, and does not require constant professional care. Accordingly, the Division's decision is AFFIRMED.

Dated: June 25, 2026

Signed

Garrison A. Todd
Administrative Law Judge

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 3rd day of August, 2026.

By: *Signed*
Name: Daniel R. Phelps II
Title: Process Improvement Manager
Office of the Commissioner
Alaska Department of Health

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