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

In the Matter of	)	
	)	
L N	)	OAH No. 17-0366-MDX
	)	Agency No.

DECISION

I. Introduction

T N applied for TEFRA Medicaid for her son, L. The issue in this case is whether L requires the level of care provided in an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID), as determined under 7 AAC 140.600, so that he is eligible for TEFRA Medicaid. The Division of Senior and Disabilities Services (SDS) reviewed L's documentation, and on February 8, 2017, determined that L did not have a qualifying diagnosis to meet the ICF/IID level of care.[1] The Division of Public Assistance (Division) denied L TEFRA benefits based on this finding.[2]

This decision concludes, based on all the evidence in the record, that L does not have a qualifying diagnosis requiring an ICF/IID level of care. As a result, L is not eligible for TEFRA. The Division's decision denying his application for TEFRA Medicaid is AFFIRMED.

II. Facts

A. Procedural History

Ms. N applied for TEFRA Medicaid for L. On February 8, 2017, the Division of Senior and Disabilities Services (SDS) rendered an ICF/IID Level of Care Determination for L denying ICF/IID Level of Care.[3] On March 28, 2017, the Division of Public Assistance (Division) notified Ms. N that L does not meet the level of care criteria for TEFRA Medicaid and that, therefore, his TEFRA Medicaid application was denied.[4] The Division's March 28 denial of benefits cited and relied upon the ICF/IID Level of Care Determination rendered by SDS.[5]

Ms. N requested a hearing on April 7, 2017, to contest the Division's denial of L's TEFRA Medicaid application.[6] L's hearing was held on May 1, 2017. L was represented by Ms. N, who appeared telephonically. The Division was represented by Angela Ybarra, who appeared

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1 Ex. E at 1-2.
2 Ex. D at 1.
3 Ex. E at 1-2.
4 Ex. D at 1-3.
5 Ex. D at 1.
6 Ex. C at 2.

telephonically. Maria Del Rosario testified telephonically on behalf of the Division. The record was left open until May 15, 2017.

B. L's Condition and Care Needs

L is approximately four years and two months old. L was exposed in utero to alcohol (second and third trimesters), spice (first and second trimesters) and tobacco (throughout gestation). L was placed with the Ns at one-month of age, and his adoption was finalized at age six-months.[7]

L presents a complex case. Aspects of his life reflect a happy child. For example, his mother describes him as having an excellent memory; he is playful, active and energetic. He enjoys trying new things and likes being independent. He is persistent and is adored by his parents and two older brothers. He loves singing songs. He also enjoys climbing and running.[8] Other aspects of L's life, however, are not as reassuring. It took approximately twelve to eighteen months for him to settle into a routine at home. He experienced night terrors until he was approximately three years old. His sleep routine is unpredictable, and he sleeps as little as one to three hours nightly, with no evidence of restorative sleep. L does not have positive peer interaction and has been known to scream "get away" when approached by other children to play. He attempts to hit and strangle the family pets. He has a tendency to leave the family home, is a sensory seeker and enjoys speed, jumping off high places and running fast. He avoids certain textures and will only eat one food at a time.[9]

As reported in a recent Individual Education Program (IEP) report, L participates in a five day per week, two and a half hour per day self-contained special education preschool class. He has made steady progress in class and is expected to continue progressing through the remainder of this year and will attend one more year of preschool before proceeding to kindergarten.[10] The IEP report states that L has strong academic skills and is working on academic, fine motor and gross motor skills as part of his preschool curriculum. However, L experiences developmental delays in the areas of social skills that will prevent him from interacting freely with his peers for the purposes of learning and socializing in an educational setting.[11] L receives occupational and speech therapy.[12]

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7 Ex. E at 4.
8 Ex. E at 5.
9 Ex. E at 4.
10 Individual Education Program (IEP) Report at 2 (dated March 9, 2017).
11 IEP at 2.
12 Ex. E at 20.

J S, PsyD, performed a neuropsychological assessment of L in 2016 when he was three years and one month old.[13] L reportedly experienced difficulty regulating his moods, communicating his needs, developmental delays, hyperactivity, sleep disturbance, impulsivity, inattention, poor social skills and limited self-care.[14] Dr. S made diagnoses for L of Specific Neurodevelopmental Disorder due to prenatal alcohol exposure (315.8/F88), and Attention Deficit Hyperactivity Disorder, Hyperactive/Impulsive Presentation (314.01/F90.1).[15] Dr. S reported L's Full Scale IQ as 82 (12th percentile), in the low average range.[16] Dr. S reported that L performed as expected for his age or within average in a number of developmental areas, including verbal and visual memory, receptive vocabulary and executive function.[17] In other areas, such as expressive vocabulary, L rated below average. Perhaps most significant, Dr. S reported:

> L's overall adaptive functioning falls in the low range for his age with particular difficulty in the areas of self-direction, health and safety, social skills, self-care skills, home living and community use.[[18]]

In addition, L scored at-risk for hyperactivity and aggression; she reported he "has a tendency to become angry quickly and has difficulty maintaining self control when faced with adversity."[19]

L was evaluated by No Name Services in a report dated July 8, 2016, at three years and three months of age, due to his history of in utero alcohol exposure.[20] No Name Services diagnosed L with static encephalopathy and alcohol exposure. No Name Services stated that L did not exhibit the growth deficiency and characteristic facial features associated with Fetal Alcohol Syndrome (FAS) and concluded that he "does not have FAS, but there was evidence of significant CNS [central nervous system] damage/dysfunction."[21] No Name Services reported that L "does not have a history of seizures."[22] Respecting language, No Name Services reported that "L presents with overall age appropriate skills in his expressive and receptive language skills

13 Ex. E at 3-13.
14 Ex. E at 1, 8-9.
15 Ex. E at 8.
16 Ex. E at 4.
17 Ex. E at 5, 8-9.
18 Ex. E at 8.
19 Ex. E at 9. *See also* Ex. E at 10 ("Emotional control is an area of great difficulty for L.").
20 Ex. E at 14-23.
21 Ex. E at 14.
22 Ex. E at 18.

(mild delay in the use of grammar), and a severe delay in his pragmatic language skills."[23] No Name Services explained further:

> L's severe social language delays are likely to make it difficult for him to accurately read situations and determine appropriate ways to act or solve problems. His difficulties with turn-taking, empathy/understanding emotions, taking multiple perspectives, and reading body cues are socially isolating and will contribute to challenges he has with peers and others.[24]

No Name Services also found that L's "fine motor skills are much below expectations,"[25] but that "[h]is pre-academic skills were judged to be age appropriate."[26]

L was evaluated for occupational therapy at three years and three months of age in a report signed by K C, OTR/L, with No Name Therapy Clinic (Report).[27] Notably, the Report notes that "L enjoys physical exertion activities," he likes riding his bicycle and "enjoys climbing at the park."[28] The Report states that L's "[o]verall scores for self-care subtest are within normal limits,"[29] but the Report concludes his fine motor skills score as "very poor."[30]

As the No Name Services report concluded, L "is left with evidence of a lifelong disability and impairments that will require external supports to be successful in the future."[31]

C. The Division's Level of Care Determination

The portion of Alaska's TEFRA program involving level of care (LOC) determinations – the only aspect of TEFRA eligibility at issue in this case – is performed by the Department of Health and Social Services, Division of Senior and Disability Services (SDS) on behalf of its sister agency, the Division of Public Assistance (Division).[32] The Division's primary eligibility determination for L is dated March 28, 2017, and is in the record as Exhibit D.[33] As explained in

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23 Ex. E at 18. The Speech and Language Evaluation by Time for Speech Pediatric Speech Therapy, signed by T L, M.A., CCC-SLP, is at Exhibit E at 27-32 (Speech Evaluation). As reported by No Name Services, the Speech Evaluation concludes that "L presents with overall age appropriate skills in his expressive and receptive language skills (mild delay in the use of grammar), and a severe delay in his pragmatic language skills." Ex. E at 32.

24 Ex. E at 20.

25 Ex. E at 20.

26 Ex. E at 21.

27 Ex. E at 24-26.

28 Ex. E at 25.

29 Ex. E at 25.

30 Ex. E at 25.

31 Ex. E at 15. Additional reports and evaluations concerning L are in the record, including Exhibit F and the supplemental IEP and Evaluation Summary and Eligibility Report (ESER) submitted by Ms. N. These materials have been considered but are not summarized here.

32 *See* Division of Public Assistance, *Aged, Disabled, and Long Term Care Medicaid Eligibility Manual* at Section 533(C)(5), reproduced at Ex. B at 16.

33 A supplemental decision document, dated May 3, 2017, is discussed further below.

Exhibit D, the Division reports that SDS reviewed the documentation in the record regarding L's condition and denied an ICF/IID level of care.[34]

The Division's decision stated that an individual seeking an ICF/IID level of care determination must meet a level of care as determined by documentation of a qualifying diagnosis. The qualifying diagnoses are: Intellectual Disability, Cerebral Palsy, Autism, Seizure Disorder or Other Intellectual Disability Related Condition. The Division noted that Dr. S's neuropsychological assessment of L reports a diagnosis for L of ICD 10 code F88 (Other Disorders of Psychological Development), which the Division states may qualify under Other Intellectual Disability Related Condition.[35]

The Division's decision states that to qualify under Other Intellectual Disability Related Condition, as defined by 7 AAC 140.600, the condition must result in "'impairment of general intellectual functioning and adaptive behavior similar to that of individuals with intellectual or developmental disabilities.'"[36] The Division stated that five areas of functioning are examined to make this determination in children L's age; the five areas are: learning, language, mobility, self-care and self-direction. The Division stated that a functional limitation must be established by documentation of a substantial delay in three or more developmental areas to qualify under Other Intellectual Disability Related Condition. A substantial functional limitation is indicated by a delay of 2 standard deviations or 25 percent, or functioning at or below the 2nd percentile.

The Division's March 28, 2017, decision determined that L had a substantial functional limitation only in the area of self-direction.[37] The Division's March 28 decision found that L did not experience a substantial functional limitation in learning, language, mobility or self-care, and referenced various reports in the record covering these topics. For example, regarding learning, the Division referenced Dr. S's neuropsychological assessment and noted he scored a Full Scale IQ of 82 (12th percentile). Regarding mobility, the Division noted that an occupational therapy report stated that L enjoyed physical activities, including climbing in the park, and that this did not indicate a substantial functional limitation in mobility. And regarding self-care, L's occupational therapy report stated that L's overall scores in self-care are within normal limits.[38] The Division's March 28 decision concluded that the documentation on L's condition did not

34 Ex. D at 1. SDS's determination is in the record as Ex. E.
35 Ex. D at 2.
36 Ex. D at 2 (quoting 7 AAC 140.600).
37 Ex. D at 2.
38 Ex. D at 2.

demonstrate impairment in adaptive or general intellectual functioning similar to individuals who are diagnosed with an Intellectual Disability as defined by 7 AAC 140.600.[39]

At the hearing, Ms. N testified that she had additional documentation concerning L she wished to submit as part of the record and for the Division to consider.[40] These materials were received after the hearing without objection and are in the record. They consist of an Individual Education Program plan for L dated March 9, 2017, and a revised Evaluation Summary and Eligibility Report (ESER) for L dated March 9, 2017. On May 3, 2017, the Division filed a Response to Additional Documents Reviewed and Submitted (Response).[41] The Division's Response reaffirmed the denial of TEFRA level of care for L. The Response again determined that L has a substantial functional limitation in the area of self-direction. Regarding self-care, the Division's Response concedes that L experiences a substantial functional limitation in the area of self-care, but reaffirmed its denial because the Division found that L did not have a substantial functional limitation in the areas of learning, language or mobility.

III. Discussion

A. TEFRA Medicaid Overview

The TEFRA Medicaid program permits families with children who meet certain disability eligibility requirements to qualify for Medicaid even if they are otherwise over the normal income limit for participation in Medicaid. States are allowed, at their option, to provide benefits to children 18 years of age or less who qualify as disabled individuals under § 1614 of the Social Security Act and who live at home rather than in an institution. Qualifying children are those who receive at-home medical care similar to that provided at a medical institution.[42] Qualification is based on the level of care the child requires.[43]

B. Relevant Alaska Medicaid Statutes and Regulations

The Alaska statute authorizing the Division to provide TEFRA Medicaid is AS 47.07.020(b)(11). The statute contains four substantive criteria and a cost criterion. First, the recipient must be 18 or younger. Second, the recipient must qualify as a disabled individual

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39 Ex. D at 2.

40 N Testimony.

41 The Division's Response indicates that it considered both the supplemental materials provided after the hearing by Ms. N and existing documents in the record as Exhibit F. The materials in Exhibit F were not originally considered by the Division in its March 28 eligibility determination; the documents in Exhibit F are from the record of a different decision, dated August 5, 2016, which is not the subject of this appeal. Ybarra Statement.

42 42 C.F.R. § 435.225.

43 The statutory provisions establishing TEFRA are in § 1902(e) of the Social Security Act, 42 U.S.C. § 1396a(e)(3). The federal regulation implementing TEFRA is 42 C.F.R. § 435.225.

under 42 U.S.C. § 1382c(a). Third, the recipient must require a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded. Fourth, it must be appropriate to provide care for the recipient outside of an institution. Finally, the estimated cost to care for the recipient outside an institution must not be greater than the estimated cost to care for the recipient inside an appropriate institution. Only the third criterion (level of care) is at issue in this case.

Alaska's regulation implementing TEFRA is 7 AAC 100.424, titled "Disabled child living at home." Regarding level of care requirements, it states in relevant part:

> (a) A child with a disability who does not qualify for SSI because of parental income or resources is eligible for Medicaid under 7 AAC 100.002(d)(5) and this section if
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> (5) the department has determined that the child needs a level of care offered in
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> (C) an inpatient psychiatric hospital, as determined under (c) of this section;
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> (c) For the purpose of determining eligibility under this section, a child requires a level of care provided in an inpatient psychiatric hospital if the child
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> (1) has a mental illness or severe emotional disturbance that (A) is diagnosed by a psychiatrist or mental health professional; (B) is likely to result in harm to self and others; and (C) has persisted six months and is expected to persist for a total of 12 months or longer;
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> (2) has at least one of the following mental health symptoms: (A) psychotic symptoms, characterized by defective or lost contact with reality, hallucinations, or delusions; (B) a suicide attempt, in the 90-day period before the date of application; (C) suicidal thoughts, in the 30-day period before the date of application, that include a plan for suicide; (D) violent behavior as the result of an emotional disturbance, in the 30-day period before the date of application, characterized by a documented attempt by the child to cause injury to a person or substantial property damage;
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> *(3) has functional impairments, relative to expected developmental levels for the child's age and at a level that qualifies the child to receive inpatient psychiatric hospitalization, in at least three of the following areas: (A) self-care; (B) interaction with the community; (C) social relationships; (D) family relationships; (E) functioning at school or work*;
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> (4) absent appropriate intervention in the home and community, requires psychiatric hospitalization as documented by a mental health professional; and

> (5) can be expected to functionally improve or can avoid further deterioration if care is provided in the home and community.[44]

Thus, the regulation has five main criteria (7 AAC 100.424(c)(1)-(5)), each of which must be satisfied to demonstrate a need for an inpatient psychiatric hospital level of care. Whether L satisfied the criteria under subsection (c)(3) is the focus of the Division's determination and this Decision.

C. Does L Experience Substantial Functional Impairments in at Least Three of the Five Developmental Areas Under 7 AAC 100.424(c)(3)?

"For a request for new or additional benefits, the burden of proof is on the applicant or recipient requesting the service, and is by a preponderance of evidence."[45] Thus, Ms. N (L) has the burden of proof. While the record shows that L presents a complex case and challenges in life, considering the overall record, Ms. N has not met her burden of demonstrating a substantial functional impairment in at least three of the developmental areas defined by 7 AAC 100.424(c)(3).

The Division concedes that the record documents that L experiences a substantial impairment with self-direction.[46] In its Response to the supplemental materials presented by Ms. N, the Division appears to concede that the record documents that L experiences a substantial impairment with self-care.[47] Thus, the question is whether Ms. N has met her burden of proving that L suffers a substantial impairment in at least one of the remaining three developmental areas: mobility, learning and language.

The record does not document a substantial functional impairment in L's mobility. To the contrary, the Report shows that L enjoys physical activities, riding his bike and climbing.[48] Likewise with learning, the record does not document a substantial functional impairment in this area. To the contrary, L has a Full Scale IQ of 82 (12th percentile), in the low average range.[49] Further, L's pre-academic skills were judged to be age appropriate.[50]

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44 7 AAC 100.424 (emphasis added).
45 7 AAC 49.135.
46 Ex. D at 2.
47 Response at 2-3.
48 Ex. E at 25.
49 Ex. E at 6.
50 Ex. E at 21.

Finally, with respect to language, L's expressive and receptive language skills were found to be age appropriate with a mild delay in grammar.[51] The record does document that L has a severe delay in pragmatic language.[52] While L's severe pragmatic language delay will likely adversely impact his social engagements,[53] Ms. N has not demonstrated by a preponderance of the evidence that this delay, along with the delays in self-direction and self-care, qualifies L to receive inpatient psychiatric hospitalization, as required by 7 AAC 100.424(c)(3). Lastly, the Division argues persuasively that pragmatic language is but a component of language, and that a delay in pragmatics alone does not constitute the entirety of the delay in this developmental area.[54]

IV. Conclusion

The Division's decision denying the application for TEFRA Medicaid is AFFIRMED.

DATED: May 17, 2017.

By: *Signed*
David J. Mayberry
Administrative Law Judge

Adoption

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

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

DATED this 20th day of June, 2017.

By: *Signed*
Name: Erin Shine
Title: Special Assistant to the Commissioner

[This document has been modified to conform to the technical standards for publication.]

51 Ex. E at 31, 32.
52 Ex. E. at 31, 32.
53 *See, e.g.*, Ex. E at 32.
54 The Division cites a policy manual addressing a statute (AS 47.80.900(6)(D)) that is not part of Alaska's TEFRA Medicaid statute (AS 47.07.020(b)(11). Ex. D at 2. While the statute in AS 47.80 is not part of Alaska's TEFRA statute, it addresses a question substantially similar to the question presented in this appeal, only in the context of a separate program regarding persons with a developmental disability.