STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[REDACTED],

Appellant
_______________________/

Docket No. 2009-14886 CMH
Case No. [REDACTED]
Load No. [REDACTED]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9, following the Appellant's request for a hearing.

After due notice, a telephonic hearing was held on [REDACTED] [REDACTED] (Appellant) appeared and testified on his own behalf. Also appearing as a witness for the Appellant was [REDACTED].

[REDACTED], appeared on behalf of [REDACTED] an agency contracted with the Michigan Department of Community Health to provide Medicaid-funded mental health specialty supports and services.

ISSUE

Does the Appellant meet service eligibility requirements as an adult with a serious mental illness?

FINDINGS OF FACT

Based upon the competent, material, and substantial evidence presented, I find, as material fact:

1. The Appellant is an adult Medicaid beneficiary, who has been receiving [REDACTED] services since [REDACTED]. His plan of service, dated [REDACTED], provides for outpatient services, which includes seeing a prescriber, and a therapist until [REDACTED]. He has diagnoses of Bi-Polar Disorder, Social Anxiety Disorder, Personality Disorder, chronic pain and obesity. *(Exhibit 1, p.20)*

2. The Appellant's , Updated Assessment reflects progress made on goals and objectives identified in his , plan of service. Medication has assisted with stabilizing the Appellant's mood, and anxiety levels are minimal as the Appellant stays at home most often due to pain and financial limitations. *(Exhibit 1, pp. 14-15)*

3. The Appellant resides with his fiancée, and assists with household chores as physically able. He watches television, primarily sports, and attends medical appointments. However, he is otherwise physically inactive due to chronic pain and obesity issues. *(Exhibit 1, p. 17)*

4. On , issued the Appellant an Adequate Action Notice informing him that medication review and outpatient services would be terminated, because goals had sufficiently been met. *(Exhibit 1, p. 25)*

5. On , the Appellant filed his Request for Hearing with the State Office of Administrative Hearings and Rules for the Department of Community Health.

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.

42 CFR 430.0

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

42 CFR 430.10

Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…

As applied to adult beneficiaries, NBHS utilizes the criteria outlined in the *MDCH/CMHSP Medicaid Managed Specialty Supports and Services Contract 1915(b)/(c) Waiver Program FY 03-04: Attachment P 3.3.1-and Attachment P 3.3.2., 10/01/02 revision;* (Contract)*.*

Severe and Persistent Mental Illness is defined in the Contract as:

> 1. Diagnoses as defined by Diagnostic and Statistical Manual-IV Version (DSM-IV)- Schizophrenia and Other Psychotic Disorder (295.xx; 297.1; 297.3: 298.8: 298.9), Mood Disorders, or Major Depressions and Bipolar Disorders 296.xx).
>
> 2. Degree of Disability-Substantial disability/ functional impairment in three or more primary aspects of daily living such that self-sufficiency is markedly reduced. This includes:
>
> > Personal hygiene and self-care,
> > Self-direction,
> > Activities of daily living,
> > Learning and recreation, or
> > Social transactions and interpersonal relationships.
>
> In older persons (55 or older), loss of functional capacity might also include:
>
> > Loss of mobility.
> > Sensory impairment,
> > Physical stamina to perform activities of daily living or ability to communicate immediate needs as the result of medical conditions requiring professional supervision, or
> > conditions resulting from long-term institutionalization.
>
> Duration-
>
> a) evidence of six continuous months of illness,

symptomatology, or dysfunction, or six cumulative months of symptomatology/dysfunction in a 12-month period, or

b) based on current conditions and diagnosis , there is a reasonable expectation that the symptoms/dysfunctions will continue for more than six months.

Prior Service Utilization-

a) four or more admissions to a community inpatient unit/facility in a calendar year, or
b) community inpatient hospital days of care in a calendar year exceeding 30 days, or
c) State hospital utilization of over 60 days in a calendar year, or
d) Utilization of over 20 mental health visits (e.g., individual or group therapy) in a calendar year.

Developmental Disability is defined in the Contract as:

If applied to an individual older than five years, a severe, chronic condition that meets all of the following requirements:

1. Is attributed to a mental or physical impairment or a combination of mental and physical impairments.

2. Is manifested before the individual is 22 years old.

3. Is likely to continue indefinitely.

4. Results in substantial functional limitation in three or more of the following areas of major life activities

* Self-care
* Receptive and expressive language
* Learning
* Mobility
* Self-Direction
* Capacity for independent living
* Economic self-sufficiency

5. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated.

Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program FY 03-04: ATTACHMENT P 3.3.1 – 10/01/02 Final MA 39

Does the Appellant meet criteria for an adult with a severe and persistent mental illness?

Does the Appellant possess a Qualifying diagnosis?

Yes. The Appellant has been diagnosed with Bi Polar Disorder. Provided he meets other criteria applicable to a determination of serious and persistent mental illness, he may qualify for CMHSP services.

Has the Appellant's diagnosis of Bi Polar Disorder resulted in substantial disability/functional impairment in three or more primary aspects of daily living such that self-sufficiency is markedly reduced?

No. The record is devoid of evidence to suggest the Appellant's physical abilities result in marked reduction of self-sufficiency. The evidence suggests that the Appellant's physical abilities are limited by chronic back pain and obesity, not by his mental health diagnosis.

For example, [redacted], progress notes convey that the Appellant continues to do fairly well on his medication regimen, and that the Appellant wishes to treat his pain with medical marijuana. The Appellant denies any auditory, visual hallucinations, or self-injurious behaviors at this time. These, as well as progress notes from other sessions, reflect that the Appellant's primary concerns are his weight and finding voluntary work at an animal clinic or nursing home.

The Appellant testified at hearing that his primary concern was whether he would be still be able to obtain pain medications should [redacted] discontinue services. He claims to have occasional suicidal thoughts, and voiced concern for running out of medication. The Appellant otherwise presented no substantive challenge to [redacted] findings or conclusions regarding his present mental health status.

DECISION AND ORDER

Based upon a preponderance of the objective medical evidence presented, I decide that [redacted] has properly concluded the Appellant no longer satisfies the *MDCH/CMHSP Medicaid Managed Specialty Supports and Services Contract 1915(b)(c) Waiver Program FY 03-04* service eligibility requirements for a person with a severe and persistent mental illness.

IT IS THEREFORE ORDERED that:

decision is AFFIRMED.

Stephen B. Goldstein
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc:

Date Mailed: 5/13/2009

***** NOTICE *****

The State Office of Administrative Hearings and Rules for the Department of Community Health may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules for the Department of Community Health will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.