STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF

[redacted]
Appellant

_____/

Docket No. 2010-16126 CMH
Case No. 82970067

DECISION AND ORDER

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

After due notice, a hearing was held on [redacted] appeared on his own behalf. [redacted], Appellant's care giver and niece-in-law, appeared as a witness on behalf of the Appellant

[redacted] (CMH), represented the CMH.

ISSUE

Did CMH properly determine the Appellant was not eligible for CMH services?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a [redacted] year-old Medicaid beneficiary. (Exhibit A).

2. [redacted] is responsible for providing Medicaid-covered services to eligible recipients in its service area and is a member of the [redacted] (PIHP).

3. The Appellant is enrolled in a Medicaid Health Plan (MHP); the [redacted]. (Exhibit A).

4. At [redacted] years of age Appellant was diagnosed with spinal muscular atrophy. (Exhibit A, p. 3).

5. The Appellant is being prescribed the medications neurontin, hydrocodone, loperamide, and metoprolol tartate by his primary care physician. (Exhibit A, p. 3).

6. Appellant is also diagnosed as having depression and is prescribed Zoloft medication for depression by his primary care physician. (Exhibit A, pp. 3, 6).

7. By age thirteen, Appellant's spinal muscular atrophy had progressed to the point he became non-ambulatory, needed use of a motorized wheelchair, needed his mother's assistance to get him out of his bed in the morning into his wheelchair and dressed, needed his brothers to carry him onto the school bus, and needed his friends to help him use the school bathroom. (Exhibit A, p. 3; Appellant's testimony).

8. By age [redacted], Appellant's spinal muscular atrophy caused substantial functional limitations in at least self-care, mobility, capacity for independent living and economic self-sufficiency. (Exhibit A, p. 3).

9. Appellant's spinal muscular atrophy manifested at least by age thirteen and is a severe, chronic condition that is likely to continue indefinitely.

10. Appellant lives with his nephew and his nephew's family. (Exhibit A).

11. Appellant does not have the use of his limbs and is dependent on others for his care. Appellant's home does not have a ramp and he can not leave his home without being carried by another person to a car. (Exhibit A, p. 1).

12. Appellant desires to participate in the community but is unable to leave his home without the assistance of another person. (Exhibits A and 1).

13. Appellant has been receiving home help services (HHS) from the Department of Human Services in the amount of 6.5 hours per day. The Appellant's HHS chore provider is his nephew's wife, [redacted].

14. Appellant is not currently enrolled in [redacted]. In or before [redacted] the Appellant requested Medicaid-covered CMH services through CMH. (Exhibit A).

15. On [redacted], a CMH social worker performed an eligibility assessment in Appellant's home. (Exhibit A).

16. The [redacted], eligibility assessment showed the Appellant

took medication for depression but was not suicidal or homicidal and had not had an inpatient mental health hospitalization. (Exhibit A, pp1).

17. The [redacted], eligibility assessment showed the Appellant was dependent on others for his care and he can not leave his home without being carried by another person to a car. (Exhibit A).

18. The [redacted], eligibility assessment showed the Appellant would not be able to escape from his home in case of emergency such as fire without assistance of another person. (Exhibits A and 1).

19. As a result of the [redacted], eligibility assessment the CMH concluded the Appellant did not have a severe and persistent mental illness and could receive his mental health services through his MHP. (Exhibit C).

20. As a result of the [redacted], eligibility assessment the CMH concluded the Appellant was not eligible for developmental disabilities (DD) services. (Exhibit C). The reason given by CMH for denial was

> …even though you were diagnosed as a child with MD you were able to go on and have a full life as evidence by a Bachelor's Degree, 2 children and business out of your home. (At our meeting you explained that the business was never a go but that you had tried different money making ideas over the years.) It has been as you aged that the toll of your diagnosis that has led to your total dependence and isolation. As this occurred after the age of 22 years you are not in our opinion eligible for the support services needed to assist you to continue to live in your present situation. (Exhibit C, p 1).

21. On [redacted], the CMH sent an Adequate Action Notice to the Appellant indicating he was not eligible for CMH case management services. The CMH notice did not provide adequate explanation for the reasons, only, "does not meet criteria." (Exhibit B).

22. The Appellant's request for hearing was received on [redacted] (Exhibit 1). The Appellant contests the denial because he seeks assistance, including an ability to participate in the community, and believes he meets the criteria for CMH services. (Exhibit 1).

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 she 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…

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b)

and 1915(c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Community Health (MDCH) operates a sections 1915(b) and 1915(c) Medicaid Managed Specialty Services waiver. Newaygo County CMH contracts with the Michigan Department of Community Health to provide specialty mental health services, including DD services. Services are provided by CMH pursuant to its contract obligations with the Department and in accordance with the federal waiver.

Medicaid beneficiaries are only entitled to medically necessary Medicaid covered services for which they are eligible.

Denial of CMH Mental Health Services

The *MDCH/CMHSP Managed Specialty Supports and Services Contract, Section 3.3* and Exhibit 3.1.1, Section III(a) Access Standards-*10/1/08, page 4,* directs a CMH to the Department's *Medicaid Provider Manual*, *Mental Health and Substance Abuse Chapter* for determining coverage eligibility for Medicaid beneficiaries.

The Department's *Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility, Section 1.6,* makes the distinction between the CMH responsibility and the Medicaid Health Plan (MHP) responsibility for Medicaid outpatient mental health benefits. The Medicaid Provider Manual sets forth the eligibility requirements as:

In general, MHPs are responsible for outpatient mental health in the following situations:	**In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations:**
□ The beneficiary is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and minimal clinical (self/other harm risk) instability. □ The beneficiary was formerly significantly or seriously mentally ill at some point in the past. Signs and symptoms of the former serious disorder	□ The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally disturbed as indicated by diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform daily living activities (or for minors, substantial interference in achievement or maintenance of developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills). □ The beneficiary does not have a current or recent (within the last 12 months) serious condition but was formerly

have substantially moderated or remitted and prominent functional disabilities or impairments related to the condition have largely subsided (there has been no serious exacerbation of the condition within the last 12 months). The beneficiary currently needs ongoing routine medication management without further specialized services and supports.	seriously impaired in the past. Clinically significant residual symptoms and impairments exist and the beneficiary requires specialized services and supports to address residual symptomatology and/or functional impairments, promote recovery and/or prevent relapse. □ The beneficiary has been treated by the MHP for mild/moderate symptomatology and temporary or limited functional impairments and has exhausted the 20-visit maximum for the calendar year. (Exhausting the 20-visit maximum is not necessary prior to referring complex cases to PIHP/CMHSP.) The MHP's mental health consultant and the PIHP/CMHSP medical director concur that additional treatment through the PIHP/CMHSP is medically necessary and can reasonably be expected to achieve the intended purpose (i.e., improvement in the beneficiary's condition) of the additional treatment.

Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility Section, October 1, 2009, page 3.

The CMH Representative testified that CMH utilized *Medicaid Provider Manual, Mental Health and Substance Abuse, Beneficiary Eligibility, Section 1.6, October 1, 2009,* page 3 to determine that the Appellant was not eligible for CMH because he did not have a severe and persistent mental illness, but could receive his treatment for depression services through his twenty MHP visits, rather than receive specialized mental health services provided through the CMH.

The [redacted], eligibility assessment showed the Appellant took medication for depression but was not suicidal or homicidal and had not had an inpatient mental health hospitalization. (Exhibit A, pp. 1). The Appellant testified he prefers not to mention suicide to others, but in fact he often thinks about suicide but does not have a means to carry it through. From the evidence the CMH had at the time it made its mental health denial determination CMH established that Appellant's condition could be managed within the mental health services offered from his health plan and its determination was proper.

Denial of CMH Developmental Disability services –

The CMH Representative testified at hearing that she personally reviewed the Appellant's eligibility assessment and sought the opinion of the [redacted] (PIHP) of which it is an affiliate and from which it receives funding for the Medicaid services it renders. In particular the CMH Representative stated she consulted the Utilization Manager and PIHP Fair Hearings Officer and both concurred with the CMH determination that Appellant did not meet the definition of developmental disability and therefore was not eligible for CMH services. (Exhibit C).

As noted above the *MDCH/CMHSP 2008 Managed Specialty Supports and Services Contract, Section 3.3 and Attachment* 3.1.1, Section III(a) Access Standards directs a CMH to the Department's *Medicaid Provider Manual*, *Mental Health and Substance Abuse Chapter* for determining coverage eligibility for Medicaid beneficiaries. The text of the introductory paragraph of Medicaid Provider Manual (MPM) Section 1.6 states that it provides guidance to PIHP's regarding eligibility for a person with a developmental disability.

However, a review of the chart provided in MPM 1.6 demonstrates that while it is instructive on eligibility for people with mental illness, it does not specifically and explicitly address people with developmental disabilities. Furthermore, *MDCH/CMHSP Managed Specialty Supports and Services Contract, Attachment 3.1.1*, (contract) instructs that the use of the Michigan Mental Health code is only to be used if the individual seeking eligibility is NOT eligible for Medicaid. This contract statement appears to disregard all Medicaid eligible persons seeking CMH services as a person with a developmental disability. This Administrative Law Judge sought clarification from the contract attachment titled, "CHMSP/HP Model Agreement: Developmental Disabilities," *Contract Attachment 6.4.5.1B, Section D. 1. Attachment 6.4.5.1B, Section D. 1.* reads:

> …Eligibility criteria for specialty developmental disability (DD) services are outlined in Attachment 1.

"Attachment 1" did not follow *Attachment 6.4.5.1B* and could not be located.

The CMH Representative indicated that the Michigan Mental Health Code definition of developmental disability was utilized by CMH to determine Appellant was not eligible for CMH services. The Service Selection Guidelines section of the current contract no longer includes the Mental Health Code definition of developmental disability and does not refer PIHPs to the Mental Health Code to determine eligibility for Medicaid-covered CMH services for a person with developmental disability. Because a clear instruction on what definition or criteria is to be used by CMHs to determine eligibility for CMH developmental disability services, in this instance it was reasonable use the Mental Health Code definition, also found in the definition section of the contract:

> (21) "Developmental disability" means either of the following:
>
> (a) If applied to an individual older than 5 years of age, a severe, chronic condition that meets all of the following requirements:
>
> (i) Is attributable to a mental or physical impairment or a combination of mental and physical impairments.
> (ii) Is manifested before the individual is 22 years old.
> (iii) Is likely to continue indefinitely.
> (iv) Results in substantial functional limitations in 3 or more of the following areas of major life activity:
>
> (A) Self-care.
> (A) Receptive and expressive language.
> (C) Learning.
> (D) Mobility.
> (E) Self-direction.
> (F) Capacity for independent living.
> (G) Economic self-sufficiency.
>
> (v) 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.
>
> *MCL 330.1100a*

After the [redacted], eligibility assessment the CMH consulted with its PIHP affiliation and concluded the Appellant was not eligible for DD services. On [redacted], the CMH sent an Adequate Action Notice to the Appellant but the notice did not provide an explanation adequate enough to understand the reason; it merely stated "does not meet criteria." (Exhibit B). The Appellant contested the denial and the CMH representative wrote the Appellant a detailed explanation for denial (Exhibit C). The reason given by CMH for denial was:

> …even though you were diagnosed as a child with MD you were able to go on and have a full life as evidenced by a Bachelor's Degree, 2 children and business out of your home. (<u>At our meeting you explained that the business was never a go but that you had tried difference money making ideas over the years</u>.) It has been as you aged that

> the toll of your diagnosis that has led to your total dependence and isolation. As this occurred after the age of 22 years you are not in our opinion eligible for the support services needed to assist you to continue to live in your present situation. (Exhibit C, p 1).

For purposes of simplifying the application of the Mental Health Code definition to Appellant's facts, in general, the Appellant must meet four criteria: 1) physical impairment, 2) manifestation before age 22, 3) physical impairment to continue indefinitely, and 4) physical impairment resulting in substantial functional limitations in three or more areas of major life activity.

There is no dispute between the parties that the Appellant met three of the criteria: 1) physical impairment, 3) physical impairment to continue indefinitely, and 4) physical impairment resulting in substantial functional limitations in three or more areas of major life activity. Consequently, the issue in this case is whether the Appellant's physical impairment manifested before age 22.

The CMH Representative testified and submitted evidence that the Appellant's physical impairment did not manifest before age 22 because he had "a full life as evidenced by a Bachelor's Degree, 2 children and business out of your home." (Exhibit C).

The Appellant testified that by age thirteen, his spinal muscular atrophy had progressed to the point he became non-ambulatory and needed use of a wheelchair. The Appellant described in detail the substantial functional limitations as a result of his muscular atrophy by age thirteen: he needed his mother's assistance to get him out of his bed in the morning, into his wheelchair and dressed; he needed his brothers to carry him onto the school bus; and he needed his friends to help him use the school bathroom. Appellant's testimony demonstrated that by the age of thirteen, Appellant's spinal muscular atrophy had substantial functional limitations in at least self-care, mobility, capacity for independent living and economic self-sufficiency. It is indisputable that Appellant's spinal muscular atrophy manifested at least by age thirteen.

The CMH Representative explained that at some point in Appellant's life he was able to get a college degree, have children and start home businesses and for that reason the CMH believed the Appellant did not meet the definition of DD. However, by a straightforward application of the undisputed facts to the law, Appellant's muscular atrophy manifested before age 22. The Appellant met all the elements of the Mental Health Code definition of DD before the age of 22 years. In Appellant's instance, the fact that he accomplished remarkable accomplishments after the age of 22 years does not dispossess him of his DD qualification.

The Appellant is receiving home help services through the Department of Human Services for his personal care. The Appellant explained his desire to participate in the community and his inability to do so without relying on an unpaid caregiver. The

Appellant stated his home businesses have not been successful, that he has lost most use of his limbs, is limited to activities inside the home and cannot escape the home in case of fire. The Appellant demonstrated he has an unmet need to participate in the community. Community access and participation is one of the purposes of the 1915(b)(c) waivers, with CMH responsible for provision of community inclusion and participation services. (See community inclusion and participation services and definitions, MPM section 17).

Summary

The CMH's adequate action notice did not provide a proper explanation as intended by the Code of Federal Regulations of the reasons it found Appellant was not eligible for mental health or DD CMH services.

The Appellant did not provide a preponderance of evidence that he met the MPM and contract requirements for a person with serious and persistent mental illness. The CMH's denial of eligibility as a person with serious and persistent mental illness was proper.

The Appellant provided a preponderance of evidence that he met the Mental Health Code eligibility requirements for DD before the age of 22. As such he is eligible for Managed Specialty Supports and Services provided through the [redacted] The CMH's denial of Appellant's eligibility as a person with DD was not proper.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that:

> The Appellant met the Mental Health Code eligibility requirements for outpatient mental health services provided through the MHP.

IT IS THEREFORE ORDERED that:

> The CMH's eligibility denial decision is REVERSED.

Lisa K. Gigliotti
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 3/3/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules 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 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.