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

Docket No. 2010-28146 CMH
Case No. [redacted]

[redacted]

Appellant
_____/

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], Ombudsman, [redacted], was also present.

Ms. [redacted], Fair Hearings Officer for [redacted] County Community Mental Health, represented the CMH. [redacted], Clinical Intake Clinician; and [redacted], Supervisor of Outpatient Department; appeared as a witness for the [redacted] County Community Mental Health (CMH).

ISSUE

Did CMH properly determine the Appellant was not eligible for CMH services as a person with developmental disability (DD)?

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] Medicaid beneficiary. (Exhibit A).

2. The Appellant has no Axis I diagnosis and an Axis II diagnosis of mild mental retardation. (Exhibit 1, p. 12).

3. [redacted] County CMH is responsible for providing Medicaid-covered services to eligible recipients in its service area and is a member of the [redacted] Alliance Prepaid Inpatient health Plan (PIHP).

4. Appellant is not currently enrolled in [redacted] County CMH. Appellant previously received DD services from CMH. (Exhibit 1, p. 12, Exhibit 3).

5. On or before [redacted], the Appellant requested Medicaid-covered CMH services through CMH. (Exhibit 1).

6. The Appellant sought CMH services because he wanted to attend a college ceramics art class and an electronics class through [redacted]. (Exhibit 1, p 3). [redacted] is a service CMH offers to its enrollees.

7. The CMH conducted a telephone screen with Appellant which resulted in the completion of a Bio Psychosocial Assessment on [redacted]. (Exhibit 1, p 3).

8. The results of the [redacted], Bio Psychosocial Assessment indicated a substantial functional limitation in two (2) areas of major life activity: receptive language (Appellant uses two hearing aids) and learning. (Exhibit 1, pp. 3-9).

9. Based on the results of the [redacted] Bio Psychosocial Assessment CMH determined there was no medically necessity established for services because Appellant had achieved his goals of community inclusion and participation, and independence. (Exhibit 1, p 15).

10. On [redacted], the CMH sent an Adequate Action Notice to the Appellant indicating he was not eligible for CMH DD services. The CMH notice stated the reasons as, "The duration and/or severity of symptoms is not sufficient." (Exhibit 1, p. 1).

11. The Appellant's request for hearing was received on [redacted] (Exhibit 2). The Appellant contests the denial because he wishes to take art classes at Creative Enterprises. (Exhibit 2).

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. [redacted] 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. *42 CFR 440.230.*

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 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). <u>The beneficiary currently needs ongoing routine medication management without further specialized services and supports.</u>	□ 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 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, 2010, page 3.

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 eligibility criteria for 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 there is no 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

There is no dispute between the parties that the Appellant met statutory criteria (21)(a)(i), (ii), and (iii) in that he has been diagnosed with mild mental retardation before [redacted] years of age that is expected to last indefinitely.

There is no dispute between the parties that the Appellant's mild mental retardation resulted in a substantial functional limitation in two areas of major life activity: Appellant met two of the 21)(a)(iv) criteria: 1) receptive language and 2) learning. (Exhibit 1, pp. 3-9). Consequently, the issue in this case is whether the Appellant's mild mental retardation resulted in a substantial functional limitation in a third area of major life activity.

The CMH witness [redacted] testified at hearing that she when she performed the Bio Psychosocial Assessment she determined that Appellant did not have a substantial functional limitation in a third area of major life activity because he has economic self-sufficiency with monthly social security income and has a payee. The CMH witness added that Appellant denied having any problems, that he was able to access the community for bowling and involvement in three churches, and mostly sought the CMH classes as an activity to keep busy.

The CMH witness [redacted] added that with regard to medical necessity the CMH followed the *Medicaid Provider Manual*, *Mental Health and Substance Abuse Chapter, Section 2.5 Medical Necessity Criteria:*

2.5.A. MEDICAL NECESSITY CRITERIA

Mental health developmental disabilities, and substance abuse services are supports, services, and treatment:

* * * * *

> - Designed to assist the beneficiary...to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.
>
> *Medicaid Provider Manual, Mental Health and Substance Abuse, January 1, 2010, page 13.* (Exhibit 1, p. 15).

Based on the results of the [redacted], Bio Psychosocial Assessment CMH determined there was no medically necessity established for services because Appellant had achieved his goals of community inclusion and participation, and independence. (Exhibit 1, p 15). The CMH witness testified that she based her determination on the fact that the Appellant was mobile, could navigate the bus system and exhibited self-direction by participating in a bowling league, churches, and requesting to attend art classes at CMH.

The Appellant testified that he wanted to attend [redacted]. The CMH Representative explained that [redacted] is a CMH service that offers art classes to beneficiaries who meet the medical necessity criteria for CMH services but because the Appellant did not meet the medical necessity criteria for CMH services, the CMH was not able to offer the classes to Appellant.

The CMH established that Appellant's mild mental retardation did not result in substantial functional limitations in three or more areas of major life activity, did not meet the definition of developmental disability, and therefore was not eligible for CMH services.

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

DECISION AND ORDER

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

> The Appellant did not meet 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 AFFIRMED.

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

cc: [redacted]

Date Mailed: 06/23/2010

***** 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.