STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
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],

Docket No. 2012-34836 CMH

[redacted]

Appellant

_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon the Appellant's request for a hearing.

After due notice, a telephone hearing was held [redacted]. Attorney [redacted] appeared and represented the Appellant. Appellant's grandmother/adoptive mother Carole Amico appeared and testified for the Appellant. [redacted] with [redacted] Circle of Support Guardianship Department, also testified as a witness for Appellant. Appellant [redacted] was present, but did not testify.

Ms. [redacted] Assistant Corporation Counsel, [redacted] Community Mental Health Authority (CMH), represented the Department. [redacted], CMH Manager of Clinical Services, appeared as a witness for the Department.

ISSUE

Does the Appellant meet the eligibility requirements for Medicaid Specialty Supports and Services through CMH?

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 male ([redacted]) Medicaid beneficiary, who is enrolled in a Medicaid Health Plan (MHP), Total Health Care, but not in any of the specialty Medicaid waivers. (Exhibit 1, Attachment C and testimony).

2. CMH is a contractor of the Michigan Department of Community Mental Health (MDCH) pursuant to a contract between these entities.

3. CMH is required to provide Medicaid covered services to Medicaid eligible clients it serves.

4. Appellant has been diagnosed with obsessive compulsive disorder, mild cognitive impairment, and obesity. Appellant has a public guardian, ARC Services of [redacted] (Exhibit 1, Attachments D & E and testimony).

5. On [redacted] CMH sent Appellant's public guardian, [redacted] an adequate action notice that Appellant did not meet eligibility criteria for services requested and his request for Supports Coordination was denied effective [redacted]. The notice informed Appellant of his right to a fair hearing. (Exhibit 1 and Attachment A).

6. On [redacted] MAHS received the Appellant's request for an Administrative Hearing. (Exhibit 1 and Attachment B).

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—

Under approval from the Center for Medicaid and Medicaid Services (CMS) the Michigan Department of Community Health (MDCH) operates a section 1915(b) waiver called the Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the MDCH to provide services under the Managed Specialty Service and Supports Waiver and other State Medicaid Plan covered services. CMH must offer, either directly or under contract, a comprehensive array of services, as specified in Section 206 of the Michigan Mental Health Code, Public Act 258 of 1974, amended, and those services/supports included as part of the contract between the Department and CMH.

[redacted], a fully licensed psychologist with CMH, testified that she reviewed the Appellant's medical records. [redacted] stated Appellant was [redacted] years old. (Exhibit 1, Attachments E & F). [redacted] stated Appellant was diagnosed with obsessive compulsive disorder, mild cognitive impairment, and obesity. [redacted] stated Appellant requested Supports Coordination through CMH. [redacted]en indicated for the Appellant to qualify for specialty Medicaid services through the CMH Appellant would have to meet the criteria for eligibility as a person with a developmental disability. (Exhibit 1).

[redacted] stated for Appellant to meet this criteria, he must have a severe chronic condition that is attributable to a physical or mental condition, or a combination of a mental and physical condition, that is manifested before the age of [redacted] years old and is likely to continue indefinitely, and results in substantial functional limitations in three or more of the following areas of major life activities: 1) self care, 2) receptive and expressive language, 3) learning, 4) mobility, 5) self direction, 6) capacity for independent living, and 7) economic self-sufficiency. (Testimony and Exhibit 1).

[redacted] stated that the Appellant's records showed he was independent in basic self care. His receptive and expressive language skills were sufficient for him to express his basic needs, understand and answer basic questions, and to understand and respond to simple one and two-step directions. [redacted] found he was independent in mobility and can drive a car. Appellant is independent in deciding what to wear, needs reminding on what to eat, and needs training on finding purposeful things to do and in making reasonable choices. [redacted] noted that the Appellant does have some difficulty managing money.

[redacted] stated, based on the information contained in the Appellant's records, Appellant did not met the criteria for services as a person with a development disability. [redacted] stated that based upon the records reviewed Appellant met only two of the substantial functional limitations in major life activities, learning and self direction, instead of the three required to be identified as a person with a developmental disability. In [redacted] professional opinion, Appellant did not qualify for services as a person with a developmental disability.

This Administrative Law Judge does not have jurisdiction to order the CMH to provide Medicaid covered services to a beneficiary who is not eligible for those services. This Administrative Law Judge determines that the Appellant is not eligible for CMH Medicaid covered services for the reasons discussed below.

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 specialized ambulatory mental health benefits. The Medicaid Provider Manual provides:

> A Medicaid beneficiary with mental illness, serious emotional disturbance or developmental disability who is enrolled in a Medicaid Health Plan (MHP) is eligible for specialty mental health services and supports when his needs exceed the MHP benefits. (Refer to the Medicaid Health Plans Chapter of this manual for additional information.) Such need must be documented in the individual's clinical record.
>
> The following table has been developed to assist health plans and PIHPs in making coverage determination decisions related to outpatient care for MHP beneficiaries. Generally, as the beneficiary's psychiatric signs, symptoms and degree/extent of functional impairment increase in severity, complexity and/or duration, the more likely it becomes that the beneficiary will require specialized services and supports available through the PIHP/CMHSP. For all coverage determination decisions, it is presumed that the beneficiary has a diagnosable mental illness or emotional disorder as defined in the most recent Diagnostic and Statistical Manual of the Mental Disorders published by the American Psychiatric Association.

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	□ The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally disturbed as indicated by diagnosis,

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>	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, April 1, 2012, page 3.

The definition section contained in the Mental Health Code, specifically MCL 330.1100a(21), defines “Developmental disability” as follows:

> (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.

(B) 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.

(b) If applied to a minor from birth to 5 years of age, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined in subdivision (a) if services are not provided.

Appellant's grandmother [redacted] testified that she adopted the Appellant so he would not be put up for adoption. Ms. [redacted] stated she has taken care of Appellant since he was [redacted] months old. He went to Warren Woods School and was in special education. She stated he has worked [redacted] different jobs, but was let go because he was too slow.

[redacted] stated Appellant will care for things at home when told to do things. He needs to be reminded, but does his chores well. [redacted] stated when she went in the hospital, due to leg amputations, [redacted] became his public guardian. Someone did not think Appellant could be left alone while she was hospitalized. [redacted] stated Appellant can't manage his money or pay bills without her assistance. She stated he can drive, but can only go places he has been before, such as his sister's or the Boy Scout meetings.

[redacted] stated the Appellant can make frozen meals. She stated she did not know what would happen if she wasn't around, but believes he would eventually take care of the house. She stated that he takes showers and takes care of himself personally.

[redacted] testified she took over for [redacted] and serves as Appellant's public guardian. [redacted] stated ARC's records for the Appellant show that Adult Protective Services had filed the petition to get ARC appointed as Appellant's public guardian. The basis was that the Appellant couldn't care for himself in his grandmother's absence.

[redacted] stated that [redacted] has applied for Social Security for the Appellant. He is now Medicaid eligible. They are also applying for services through Michigan Rehabilitation Services. [redacted] stated the Appellant interacts with others at home and at the Boy Scout meetings. He also plays video games.

[redacted] stated she agreed with the two areas where CMH found substantial functional limitations. However, she believes also that the Appellant does not have the capacity for independent living. [redacted] does not believe the Appellant can successfully live without his grandmother's support. He has difficulty with social interactions, difficulties dealing with money, and could be vulnerable as it relates to his money management. [redacted] pointed out that the Appellant needs reminders to do chores, and would have trouble living independently.

In this case, the CMH applied the proper eligibility criteria to determine whether Appellant was eligible for Medicaid Covered mental health services and properly determined he is not. The information available to the CMH at the time it determined he was not eligible for services showed he did not meet the substantial functional limitations requirement to be identified as a person with a developmental disability.

The testimony of the Appellant's witnesses does not change the previous decision of CMH. The testimony demonstrates at most that the Appellant may have some difficulties with living alone. However, the Appellant has not met his burden of showing that he has a substantial functional limitation in his ability to live independently, i.e., that he does not possess the capacity for independent living. Accordingly, Appellant does not meet the eligibility criteria for Medicaid Specialty Supports and Services through CMH.

DECISION AND ORDER

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

The CMH properly determined that the Appellant does not meet the eligibility requirements for Medicaid Specialty Supports and Services through CMH.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

William D Bond

William D. Bond
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 5-3-12

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.