STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
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IN THE MATTER OF:

[redacted]

Docket No. 2013-14493 CMH
Case No. [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 Wednesday, [redacted]. [redacted], Appellant's [redacted] and guardian appeared and testified on behalf of the Appellant. Appellant was present, but did not testify.

[redacted], [redacted] for Ottawa County, appeared on behalf of Ottawa County Community Mental Health Authority (CMH), and represented the Department. [redacted], MSW, Access Center Coordinator, [redacted], LLMSW, an Access Center Clinician, and [redacted], Mental Health Program Supervisor and Fair Hearing Officer appeared as witnesses 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 (DOB: 5[redacted]) Medicaid beneficiary, who receives social security benefits, and has Medicare and Tricare insurance. (Exhibit A, p. 12 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 autistic disorder and borderline intellectual functioning with a full scale IQ of 76. Appellant's [redacted] acts as Appellant's plenary guardian and payee. (Exhibit A, pp.11-12, Exhibit B and testimony).

5. On [redacted], [redacted], LLMSW, had an appointment with Appellant and his [redacted] for a routine eligibility screening in the CMH Access Center. [redacted] determined that Appellant did not meet the eligibility criteria to receive services as a person with a developmental disability. She determined that Appellant did have a mental impairment that had manifested itself prior to the age of 22 and was likely to continue indefinitely, but he did not have substantial limitations in three or more areas of major life activity. (Exhibit A, pp. 11-12, Exhibit B, and testimony).

6. On [redacted], CMH notified Appellant's [redacted] and guardian that Appellant did not meet eligibility criteria for services as a person with a developmental disability. (Exhibit B).

7. On [redacted], MAHS received the Appellant's request for an Administrative Hearing. (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 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], MSW, the Access Center Coordinator, stated that in order 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. He further stated to meet this criteria, Appellant must have a severe chronic condition that is attributable to a physical or mental impairment, or a combination of the two, that occurred before the age 22 and is likely to continue indefinitely, and results in substantial functional limitations in three or more of seven life areas: 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 A, pp. 1-2, 8-10).

[redacted], LLMSW, an Access Center Clinician, stated she met with Appellant and his [redacted] on [redacted] for an eligibility assessment. She stated they went over the areas of major life activities to determine if he met the criteria for eligibility. [redacted] acknowledged that Appellant did have a mental impairment, autistic disorder, but found he was not qualified because he did not have substantial functional limitations in three or more of the seven areas of major life activities. She stated that she conducted her assessment

with the Appellant and his [redacted] and also reviewed his previous records from [redacted]

[redacted] stated in regards to self care, Appellant was independent in performing bathing, dressing, toileting, and eating. As for his receptive and expressive language, Appellant was able to communicate with others and express his wants and needs, he was able to follow simple multi-step instructions, and according to his past records has a verbal IQ of 81. She found that Appellant does not have a substantial limitation in learning, he has a full scale IQ of 76 which places him in the borderline functioning range, but he can read and spell at the 8th grade level and performs math at the 6th grade level. [redacted] found Appellant was independent in mobility, he was able to transfer and ambulate safely without monitoring or assistance.

[redacted] did find that Appellant had a substantial functional limitation in the area of self direction. He has his [redacted] as a guardian and payee who helps Appellant make decisions in his best interest in regards to medical, financial, housing, legal and vocational needs. Appellant was found lacking in safety skills, and did not understand the proper use of 911 or alternatives to calling 911 in case of an emergency.

Finally, [redacted] found that Appellant did not have substantial limitations in the capacity for independent living or economic self-sufficiency. He was able to perform some household chores, make himself some simple snacks and meals, pick out items from the store, do some shopping and get appropriate change, and he has good money skills. [redacted] noted that Appellant had done some work in sheltered workshops. He also has Medicaid, Medicare, private insurance, and receives Social Security benefits which qualifies him as being self-sufficient.

[redacted] stated based on her assessment and the information contained in the Appellant's previous records Appellant did not meet the criteria for services as a person with a development disability. [redacted] stated Appellant met only one of the substantial functional limitations in major life activities, 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 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</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.

specialized services and supports.	☐ 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, [redacted], page 3.

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

> "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:
>
> b. Self-care.
>
> c. Receptive and expressive language.

d. Learning.

e. Mobility.

f. Self-direction.

g. Capacity for independent living.

h. Economic self-sufficiency.

i. 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.

i. 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 [redacted] and guardian testified that since the Appellant's [redacted] died and Appellant came to live with him, he has been trying to get the Appellant gainfully employed someplace. Appellant's [redacted] stated he was just trying to get his [redacted] a job. Appellant loves working and that is all he was trying to do. Appellant's [redacted] stated he has called Michigan Rehabilitation Services, Love Network, and Cascade Engineering and got nothing.

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 was 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 [redacted] does not change the previous decision of CMH. Appellant's [redacted] did not contest the findings made by CMH. Rather he simply stated that all he was trying to do was to get his [redacted] a job. In short, the Appellant has not met his burden of showing that he has a substantial functional limitation in three or more areas of major life activity. 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**.

/s/

William D. Bond
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: January 18, 2013

***** 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.