

**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) 373-4147

IN THE MATTER OF

██████████,

Appellant

Docket No. 2013-44616 CMH
Case No.

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 ██████████. ██████████ appeared on behalf of the Appellant. Her witness was the Appellant, ██████████. ██████████, attorney, represented the ██████████ Community Mental Health Authority (██████████); hereinafter, the Department. Her witnesses were [Department contractors] ██████████, program manager for home based services ██████████ and ██████████, clinical supervisor.

PRELIMINARY MATTER

At hearing the parties stipulated to change the word "receiving" to "authorized" in the Department's Hearing Summary.

ISSUE

- Did the Department properly deny continuation of home based services (HBS) and community living supports (CLS)?

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 ██████-year-old Medicaid beneficiary receiving services from the CMH. (Appellant's Exhibit #1)
2. The Appellant is receiving services through ██████████ one of the Department's contracted providers. (Department's Exhibit A – summary)
3. The Appellant is identified as a person with Attention deficit/hyperactivity disorder NOS, Oppositional defiant disorder, Adjustment disorder with

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mixed disturbed emotions conduct – she has behavioral and educational problems. (Department’s Exhibit A, sub B: 6 of 7)

4. The Appellant has received services from the Department beginning on or about ██████████. (Department’s Exhibit A, sub C: 4 of 4)
5. Until ██████████ the Appellant was receiving Home Based Services and Community Living Supports. (Department’s Exhibit A, sub A:1 of 2)
6. On ██████████ the Appellant’s services [HBS and CLS] were terminated based on a clinical determination that the Appellant no longer met the eligibility criteria for those services. (Department’s Exhibit A - summary and See Testimony)
7. The Department advised the Appellant that she would be transitioned to a community based program. (Department’s Exhibit A - summary and sub D: 12 of 36)
8. Based on the clinician’s evaluation and testing it was explained to the Appellant and her mother that the Appellant required therapy, but that her needs were not so serious that she required HBS. (See Testimony of ██████████ and Department’s Exhibit A, sub D: 10-12 of 36)
9. The Appellant was advised of her denial and transition to Community Outreach Program (COP) by Advance Action Notice sent ██████████ ██████████ to be effective ██████████. – “services continued pending outcome of hearing.” (Department’s Exhibit A – summary and sub A: 1 of 2)
10. Her further appeal rights were contained therein.
11. The Appellant’s CAFAS score as of ██████████ was “50.” (Department’s Exhibit A, sub C: 4 of 4 and See Testimony)
12. The instant appeal was received by the Michigan Administrative Hearing System for the Department of Community Health on ██████████. (Appellant’s 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

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...

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

The Secretary may by waiver provide that a State plan approved under this title may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded...

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 section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c) Habilitation Supports Waiver (HSW). The OCCMHA contracts with the Michigan Department of Community Health to provide those services - in this case through their subcontractor, Easter Seals.

The CMH remains the entry point for the provision of comprehensive mental health services appropriate to the conditions of the individuals located within their service area [Oakland County] – regardless of ability to pay. [MCL 330.1206]. The CMH is certified by the Department (MDCH) under MCL 330.232a of the Michigan Mental Health Code to act as an approved Medicaid provider offering either directly, or indirectly or under contract the above referenced comprehensive array of services and supports referenced in the Medicaid Provider Manual (MPM). See MPM §17 *et seq.* The service criterion for this provider is medical necessity.

The Department’s policy regarding medical necessity provides as follows:

MEDICAL NECESSITY CRITERIA

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

[] MEDICAL NECESSITY CRITERIA

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

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- 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.

MPM, Mental Health []; §2.5, January 1, 2013, pp. 12-13,

The MPM has specific criteria for eligibility of HBS:

HOME-BASED SERVICES

Mental health home-based services programs are designed to provide intensive services to children and their families with multiple service needs who require access to an array of mental health services. The primary goals of these programs are to support families in meeting their child's developmental needs, to support and preserve families, to reunite families who have been separated, and to provide effective treatment and community supports to address risks that may increase the likelihood of a child being placed outside the home. Treatment is based on the child's needs, with the focus on the family unit.

The service style must support a family-driven and youth-guided approach, emphasizing strength-based, culturally relevant interventions, parent/youth and professional teamwork, and connection with community resources and supports.

AGE SEVEN THROUGH SEVENTEEN

Decisions regarding whether a child or adolescent has a serious emotional disturbance and is in need of home-based services is determined by using the following dimensions: the child has a diagnosable behavioral or emotional disorder, substantial functional impairment/limitation of major life activities, and duration of the condition. For children age seven to seventeen, the Child and Adolescent Functional Assessment Scale (CAFAS)¹ is used to make discriminations within the functional impairment dimension. All of the dimensions, as well as family voice and choice, must be considered when determining if a child is eligible for home-based services.

MPM, §§7 and 7.2.C, Mental Health and [], *Supra*

¹ To be considered qualified for HBS the child would need to demonstrate a score of 80 or more on the CAFAS testing. *Supra*

In this appeal there was no dispute that the Appellant required services or that she does not require further services. Based on a review of the evidence and the testimony it is undisputed that the Appellant demonstrated clinical improvement and improved CAFAS scoring. Accordingly, a denial of continued HBS and CLS therapies with transition to community oriented services was properly ordered by the Department.

The Department's witness Ryeson testified that she believes the Appellant still needs assistance, but that based on the CAFAS scoring - community outreach now presents as the least restrictive alternative for the child.

Ryeson further explained that the vast improvement in scoring from an initial [undesirable] high of 90 on ██████████ to a consistent scoring of "50" demonstrated program effectiveness and observable improvement in the Appellant's behavior. See FN 1

The Appellant's representative disputed the accuracy of the CAFAS scoring owing to "gaps" in HBS. She said that the CAFAS scoring did not consider a suspension from school and the damages wrought by the Appellant in her home. She said this was mostly a "paperwork" driven analysis.

The Appellant testified that she was suspended from school for striking a male student who was teasing her and that "last year" she put a hole in the wall of her bedroom. [The Department's representative properly observed that the negative action undertaken by the Department on ██████████ did not reach back to previous calendar quarters of service reflected in the incidents described by the Appellant and her representative].

The Department's representative argued that the Appellant's CAFAS scoring is reviewed quarterly and that she [the Appellant] is continuously evaluated. Her witness, Ryeson, also stated that HBS can be reinstated on future demonstration of need. The Department's evidence had much documentation of "Meaningful and reliable improvement." See Department's Exhibit A – throughout.

The Appellant's representative argued that continued CLS and HBS would help "keep her in line and avoid the destruction..." which took place earlier. As for CLS the Appellant's representative acknowledged the Appellant's beginning the transition to community outreach programs as early as ██████████. She understood improvement was taking place – thus less need for services.

Clearly, the Appellant has failed to preponderate her burden of proof to establish that continuation of CLS and HBS were medically necessary. The Department in providing its services met the standards established under policy to meet the "child's needs." The policy standards and the achievement of the goals they represent demonstrate a successful outcome and transition to a less restrictive alternative for the Appellant.

Furthermore, exclusion of CLS for duties otherwise the responsibility of the parent(s) is supported in the Medicaid Provider Manual (MPM) which states:

CRITERIA FOR AUTHORIZING

The authorization and use of Medicaid funds for any of the B3 supports and services, as well as their amount, scope and duration, are dependent upon:

- The Medicaid beneficiary's eligibility for specialty services and supports as defined in this Chapter; and
- The service(s) having been identified during person-centered planning; and
- The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter; and
- The service(s) being expected to achieve one or more of the above-listed goals as identified in the beneficiary's plan of service; and
- Additional criteria indicated in certain B3 service definitions, as applicable.

Decisions regarding the authorization of a B3 service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The B3 supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports. Natural supports mean unpaid assistance provided to the beneficiary by people in his/her network (family, friends, neighbors, community volunteers) that are willing and able to provide such assistance. It is reasonable to expect that parents of minor children with disabilities will provide the same level of care they would provide to their children without disabilities. MDCH encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service.

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Provider qualifications and service locations that are not otherwise identified in this section must meet the requirements identified in the General Information and Program Requirement sections of this chapter. (Emphasis supplied)

MPM, Mental Health [] §17.2, January 1, 2013, p. 111

The Department's denial of continued HBS and CLS services with transition to a community outreach program was properly decided and based on policy. While the needs of the child can change - today, the evidence preponderates in support of the Department and its decision to terminate CLS and HBS.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the CMH properly denied continued HBS and CLS.

IT IS THEREFORE ORDERED that

The Department's decision is AFFIRMED.

/s/

Dale Malewska
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [REDACTED]

Date Signed: 7/29/2013

Date Mailed: 7/29/2013

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***** NOTICE *****

The Michigan Administrative Hearing System 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.