

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. 2014-1360 CMH
Case No. ██████████

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, upon Appellant's request for a hearing.

After due notice, a hearing was held on ██████████. Appellant appeared on her own behalf. Appellant's witnesses were her parents ██████████ and ██████████. ██████████, Fair Hearing Officer, represented Respondent, ██████████ (CMH or Department). ██████████, LBSW, Case Manager; ██████████, Psychologist; and ██████████, Operations Manager appeared as witnesses for the CMH.

Appellant indicated at the outset of the hearing that she did not wish to be in the room when the Department witnesses testified, or when her parents testified. As such, Appellant was allowed to wait in the lobby during the testimony of the Department's witnesses and her parents. Appellant was given the opportunity to write questions for the Department witnesses ahead of time, but she declined. Appellant did send in two questions during the testimony of ██████████ and ██████████, which were answered on the record. ██████████ and ██████████ also summarized their testimony for Appellant before Appellant testified.

ISSUE

Did the Department properly terminate Appellant's 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. Appellant is a ██████-year-old Medicaid beneficiary, born ██████████, who is diagnosed with Asperger's Syndrome. (Exhibit A, Attachment A, p 1)

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2. Appellant has always struggled with boundaries of appropriateness in numerous social situations including family functions. Appellant has always had employment concerns with how she is going to interact with fellow co-workers, management and customers since she has had issues in these areas in the past. (Exhibit A, Attachment A, p 1)
3. Appellant lives independently in her own apartment in ██████████, Michigan. Appellant is able to handle all of the responsibilities of independent living with the assistance of her family and support network. (Exhibit A, Attachment B, p 1)
4. Appellant currently attends ██████████ located in ██████████, Michigan. She plans on getting her degree in photography but would like to continue pursuing other fields of interest. Appellant stays involved with her college coordinator and is able to get extra help as needed with a tutor. (Exhibit A, Attachment B, p 1)
5. Appellant is in good physical health and takes good care of herself physically. Appellant schedules her own medical appointments and advocates for herself during her appointments. Appellant also conducts research on the internet regarding her medications and mental health diagnoses. (Exhibit A, Attachment B, p 2)
6. Appellant uses the ██████████ for virtually all of her transportation needs, although she has had numerous issues with ██████████ staff and drivers over the years. (Exhibit A, Attachment B, p 2; Testimony)
7. Appellant has been receiving Case Management Services and Individual Therapy through CMH. (Exhibit A, Attachment B)
8. Following Appellant's Annual Clinical Assessment on ██████████, Appellant was informed that she no longer met the criteria for ongoing CMH services. Appellant's services were continued for 90 days to allow her to transition to alternative options. (Exhibit A, Attachment A, p 7)
9. On ██████████, the CMH issued an Advance Action Notice to Appellant informing her that her CMH services would be terminated effective ██████████. (Exhibit A, Attachment G)
10. On ██████████, the Michigan Administrative Hearing System received the hearing request filed on Appellant's behalf. (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...

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) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. CMH contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. See *42 CFR 440.230*.

The applicable sections of the Medicaid Provider Manual (MPM) provide:

2.5 MEDICAL NECESSITY CRITERIA

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

2.5.A. 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.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on person centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.
- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services that are:
 - deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;

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- experimental or investigational in nature; or
- for which there exists another appropriate, efficacious, less-restrictive and cost effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or
- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based solely on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

*Medicaid Provider Manual
Mental Health & Substance Abuse Chapter
July 1, 2013, pp 12-14*

The Medicaid Provider Manual also lays out the responsibilities of Medicaid Health Plans (MHP's) and CMH's:

<p>In general, MHPs are responsible for outpatient mental health in the following situations:</p> <ul style="list-style-type: none">□ 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	<p>In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations:</p> <ul style="list-style-type: none">□ <u>The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally disturbed</u> 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
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<p>serious exacerbation of the condition within the last 12 months). The beneficiary currently needs ongoing routine medication management without further specialized services and supports.</p>	<p>to address residual symptomatology and/or functional impairments, promote recovery and/or prevent relapse.</p> <p><input type="checkbox"/> 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.</p>
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*Medicaid Provider Manual
Mental Health & Substance Abuse Chapter
July 1, 2013, p 3*

Appellant's case manager testified that she is a developmental disability case manager with CMH, that she is a Licensed Bachelor Social Worker (LBSW) and a Qualified Mental Health Retardation Professional. Appellant's case manager indicated that she first discussed with Appellant the closing of her case on ██████████ during Appellant's Individualized Plan of Service (IPOS) meeting. Appellant's case manager testified that Appellant's case was closed because it was determined that she no longer met the criteria for CMH services. Appellant's case manager indicated that services were continued for 90 days so that she could assist Appellant in transitioning to other services available in the community.

Appellant's CMH therapist testified that he first discussed the closure of Appellant's case with her during a regularly scheduled therapy appointment on ██████████ and that they had 8 additional therapy sessions after that date and before Appellant's case was closed. Appellant's CMH therapist testified that he discussed with Appellant during those therapy sessions the transitioning of Appellant's services to other providers. Appellant's CMH therapist indicated that Appellant was very angry when she learned that her case was being closed. Appellant's CMH therapist testified that he did not believe that the goals he and Appellant had set for their therapy had been met and that Appellant will need therapeutic interventions indefinitely.

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The CMH Operations Manager testified that she is the supervisor of Appellant's case manager. The CMH Operations Manager indicated that upon review of the case manager's documentation of Appellant's case, she felt that Appellant did not meet the criteria for continued CMH services as a person with a serious mental illness of developmental disability. The CMH Operations Manager testified that her review of Appellant's psychosocial assessment showed that Appellant did not have substantial functional limitations in 3 out of the 7 listed criteria for persons with a developmental disability and that Appellant's diagnosis did not constitute a serious mental illness. The CMH Operations Manager testified that Appellant's case manager attempted to connect Appellant with other service providers during the transition period and that Appellant's case manager had offered to go with Appellant to her first appointments with those providers to ease the transition.

Appellant testified that it took a couple of years for her to trust her CMH therapist and that they were now just getting into the meat of her problems. Appellant indicated that she did not think it was right that the CMH Operations Manager was the one who decided to close her case given that she has never met with Appellant. Appellant testified that she does not always express herself correctly or fully, even to her case manager or her therapist, so the documentation in her records relied upon by CMH to close her case was not even complete or accurate. Appellant indicated that just because she can bathe herself and schedule her own doctor's appointments does not mean that she does not have a serious mental illness. Appellant testified that she is not mentally healthy as she is ■ years old, lives off the government and wants much more out of her life than what she has now. Appellant indicated that she cannot achieve these goals without the assistance of CMH and that she has only gotten as far as she has because of the help she has received through CMH. Appellant testified that she has been very irritable and depressed for the past couple of years since a friend of hers passed away. Appellant testified that she has serious problems interacting with people and just in the last week got into it with the public transportation folks as well as her DHS worker and the DHS workers' supervisor. Appellant testified that she is afraid that if she loses her CMH services she will become severely autistic again.

Appellant's mother testified that she is concerned that Appellant's services have been terminated. Appellant's mother indicated that Appellant needs CMH services so that she can continue to make progress in her life. Appellant's mother testified that it is because of CMH's influence that Appellant has flourished. Appellant's mother testified that Appellant sees things in black and white and she needs help because she lacks common sense, especially in social situations. Appellant's mother indicated that Appellant has been exploited by persons in the past, including men. Appellant's mother also indicated that Appellant is trying to assert independence from her mother, so her mother cannot be the resource she would like to be. Appellant's mother indicated that Appellant will regress without CMH's continued involvement.

Appellant's father testified that he works in the field of Adult Protective Services and that Appellant is a classic vulnerable adult. Appellant's father indicated that Appellant has

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obsessive behaviors which can affect her health, such as drinking large amounts of cola. Appellant's father testified that Appellant wraps a lot her guidance with CMH and because of her trust with CMH she has become very dependent on them. Appellant's father indicated that Appellant has many social problems and cannot understand some basic rules of human interaction. Appellant's father testified that these problems have led to difficulties with public transportation and he is surprised in some ways that she has not already been kicked off public transportation permanently.

Based on the evidence presented, Appellant did not prove, by a preponderance of the evidence, that the termination of her CMH services was improper. The evidence shows that Appellant lives independently in her own apartment in ██████████, Michigan and is able to handle all of the responsibilities of independent living with the assistance of her family and support network. Appellant currently attends ██████████ located in ██████████, Michigan and she plans on getting her degree in photography but would like to continue pursuing other fields of interest. Appellant is in good physical health and takes good care of herself physically. Appellant schedules her own medical appointments and advocates for herself during her appointments. Appellant also conducts research on the internet regarding her medications and mental health diagnoses. Appellant's transportation needs are met through the ██████████ ██████████.

While it is clear that Appellant has become very comfortable with her CMH service providers, and that it will be very difficult for her to transition to other services for which she is eligible, that fact alone is not enough to overturn the Department's decision. CMH services are for those who are severely mentally ill or chronically developmentally disabled. Appellant, although she has many difficulties, is not either of those things. Appellant was able to handle herself professionally during the hearing, even though she was unsure she would be able to control herself. Appellant did a very good job of presenting her position and, in doing so, supported the Department's contention that she is not severely mentally ill or chronically developmentally disabled. Appellant also has health insurance through Medicaid which will cover individual and group therapy going forward and there are other resources in the community to assist her.

Accordingly, the Department's termination of Appellant's CMH services must be upheld because those services are no longer medically necessary.

[REDACTED]
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The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly terminated Appellant's CMH services.

IT IS THEREFORE ORDERED that:

The Department's decision is **AFFIRMED**.



Robert J. Meade
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

[REDACTED]
cc: [REDACTED]

Date Signed: November 22, 2013

Date Mailed: November 22, 2013

***** 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.